1 A bill to be entitled
2 An act relating to affordable health coverage; amending s.
3 112.363, F.S.; specifying that coverage provided through
4 the Cover Florida Health Care Access Program is considered
5 health insurance coverage for the purposes of determining
6 eligibility for the state retiree health insurance
7 subsidy; amending s. 408.909, F.S.; revising the
8 definition of the term "health flex plan"; revising
9 program requirements for approval of plans by the Agency
10 for Health Care Administration; revising eligibility
11 requirements; providing certain exemptions from the 6-
12 month lapse in coverage requirement; eliminating the
13 expiration date of the health flex plan program; creating
14 s. 408.9091, F.S.; creating the Cover Florida Health Care
15 Access Program; providing a short title; providing
16 legislative intent; providing definitions; requiring the
17 agency and the Office of Insurance Regulation of the
18 Financial Services Commission within the Department of
19 Financial Services to jointly administer the program;
20 providing program requirements; requiring the development
21 of guidelines to meet minimum standards for quality of
22 care and access to care; requiring the agency to ensure
23 that the Cover Florida plans follow standardized grievance
24 procedures; requiring the office and the agency to oversee
25 changes to plan benefits; requiring the Executive Office
26 of the Governor, the agency, and the office to develop a
27 public awareness program; authorizing public and private
28 entities to design programs to encourage or extend

29 incentives for participation in the Cover Florida Health
30 Care Access Program; requiring the agency and the office
31 to announce an invitation to negotiate for Cover Florida
32 plan entities to design a coverage proposal; requiring the
33 invitation to negotiate to include certain guidelines;
34 providing certain conditions under which plans are
35 disapproved or withdrawn; authorizing the agency and the
36 office to announce an invitation to negotiate for
37 companies that offer supplemental insurance or discount
38 medical plans; requiring the agency and the office to
39 approve at least one plan entity; authorizing the agency
40 and the office to approve one regional network plan in
41 each existing Medicaid area; providing that certain
42 licensing requirements are not applicable to a Cover
43 Florida plan; providing that Cover Florida plans are
44 considered insurance under certain conditions; excluding
45 Cover Florida plans from the Florida Life and Health
46 Insurance Guaranty Association and the Health Maintenance
47 Organization Consumer Assistance Plan; providing
48 requirements for eligibility for a Cover Florida plan;
49 requiring each Cover Florida plan to maintain and provide
50 certain records; providing that coverage under a Cover
51 Florida plan is not an entitlement and does not give rise
52 to a cause of action; requiring the agency and the office
53 to evaluate the program and submit an annual report to the
54 Governor and the Legislature; authorizing the agency and
55 the Financial Services Commission to adopt rules; creating
56 s. 408.910, F.S.; establishing the Florida Health Choices

57 Program; providing legislative intent; providing
58 definitions; providing program purpose and components;
59 providing employer eligibility criteria; providing
60 individual eligibility criteria; providing employer
61 enrollment criteria; providing vendor, product, and
62 service eligibility criteria; providing for individual
63 participation regardless of subsequent job status or
64 Medicaid eligibility; providing individual enrollment
65 criteria; providing vendor enrollment criteria; providing
66 for participation by health insurance agents; providing
67 criteria for products available for purchase; providing
68 criteria for product pricing; providing for an
69 administrative surcharge; providing for an exchange
70 process; providing for enrollment periods and changes in
71 selected products; providing methods for the pooling of
72 risk; providing for exemptions from certain statutory
73 provisions, mandated offerings and coverages, and
74 licensing requirements; creating the Florida Health
75 Choices, Inc.; requiring the department to supervise any
76 liquidation or dissolution of the corporation; providing
77 for corporate governance and board membership and terms;
78 providing for reimbursement for per diem and travel
79 expenses; providing for powers and duties of the
80 corporation; requiring the corporation to coordinate with
81 the Department of Revenue to develop a plan by January 1,
82 2009, for creating tax exemptions or refunds for
83 participating in the program; requiring the corporation to
84 submit an annual report to the Governor and Legislature;

85 authorizing the corporation to establish and enforce
86 certain program integrity measures; amending s. 409.811,
87 F.S.; revising the definition of the term "premium
88 assistance payment"; creating s. 624.1265, F.S.; exempting
89 certain nonprofit religious organizations from
90 requirements of the Florida Insurance Code; preserving
91 certain authority of such organizations; requiring such
92 organizations to provide certain notice to prospective
93 participants; providing notice requirements; amending s.
94 627.602, F.S.; requiring an insurance policy that includes
95 coverage for dependent children to comply with specified
96 provisions relating to dependent coverage; amending s.
97 627.653, F.S.; requiring participation of employees in
98 group insurance policies or group health benefit plans
99 issued or renewed after a specified date; providing
100 conditions for employers and employees to opt out of such
101 coverage; amending s. 627.6562, F.S.; specifying the types
102 of insurance policies that must provide for dependent
103 coverage; extending the qualifying age for dependent
104 coverage from 25 to 30 years; revising eligibility
105 requirements for dependents to receive continued coverage;
106 providing clarifications and limitations of dependent
107 coverage; providing mechanisms for reinstatement of
108 dependent coverage; providing for payment of premium;
109 requiring approval of premium payment requirements by the
110 office; providing notice requirements for reinstated
111 coverage of dependents; providing applicability; amending
112 s. 627.6699, F.S.; requiring participation of employees in

113 health maintenance contracts or policies issued or renewed
114 after a specified date; providing conditions for employers
115 and employees to opt out of such coverage; amending s.
116 641.31, F.S.; requiring participation of employees in
117 policies or health maintenance contracts issued or renewed
118 after a specified date; providing conditions for employers
119 and employees to opt out of such coverage; requiring all
120 heath maintenance contracts that provide coverage for
121 family members to comply with certain statutory
122 provisions; amending s. 641.402, F.S.; revising the
123 definition of the term "basic services" to include certain
124 hospital inpatient services; revising the definitions of
125 the terms "prepaid health clinic" and "provider";
126 providing an effective date.
127
128 Be It Enacted by the Legislature of the State of Florida:
129
130 Section 1. Paragraph (d) of subsection (2) of section
131 112.363, Florida Statutes, is amended to read:
132 112.363 Retiree health insurance subsidy.--
133 (2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.--
134 (d) Payment of the retiree health insurance subsidy shall
135 be made only after coverage for health insurance for the retiree
136 or beneficiary has been certified in writing to the Department
137 of Management Services. Participation in a former employer's
138 group health insurance program is not a requirement for
139 eligibility under this section. <u>Coverage issued pursuant to s.</u>

140 408.9091 is considered health insurance for the purposes of this
141 section.
142 Section 2. Paragraph (e) of subsection (2) and subsections
143 (3), (5), and (10) of section 408.909, Florida Statutes, are
144 amended to read:
145 408.909 Health flex plans.--
146 (2) DEFINITIONS.--As used in this section, the term:
147 (e) "Health flex plan" means a health plan approved under
148 subsection (3) which guarantees payment for specified health
149 care coverage provided to the enrollee who purchases coverage as
150 an individual, directly from the plan as a small business, or
151 through a small business purchasing arrangement sponsored by a
152 local government.
153 (3) PROGRAM.--The agency and the office shall each approve
154 or disapprove health flex plans that provide health care
155 coverage for eligible participants. A health flex plan may limit
156 or exclude benefits or provider network requirements otherwise
157 required by law for insurers offering coverage in this state,
158 may cap the total amount of claims paid per year per enrollee,
159 may limit the number of enrollees, or may take any combination
160 of those actions. A health flex plan offering may include the
161 option of a catastrophic plan or a catastrophic plan
162 supplementing the health flex plan.
163 (a) The agency shall develop guidelines for the review of
164 applications for health flex plans and shall disapprove or
165 withdraw approval of plans that do not meet or no longer meet
166 minimum standards for quality of care and access to care. The
167 agency shall ensure that the health flex plans follow

168 standardized grievance procedures similar to those required of
169 health maintenance organizations.
170 (b) The office shall develop guidelines for the review of
171 health flex plan applications and provide regulatory oversight
172 of health flex plan advertisement and marketing procedures. The
173 office shall disapprove or shall withdraw approval of plans
174 that:
175 1. Contain any ambiguous, inconsistent, or misleading
176 provisions or any exceptions or conditions that deceptively
177 affect or limit the benefits purported to be assumed in the
178 general coverage provided by the health flex plan;
179 2. Provide benefits that are unreasonable in relation to
180 the premium charged or contain provisions that are unfair or
181 inequitable or contrary to the public policy of this state, that
182 encourage misrepresentation, or that result in unfair
183 discrimination in sales practices;
184 3. Cannot demonstrate that the health flex plan is
185 financially sound and that the applicant is able to underwrite
186 or finance the health care coverage provided; or
187 4. Cannot demonstrate that the applicant and its
188 management are in compliance with the standards required under
189 s. 624.404(3).
190 (c) The agency and the Financial Services Commission may
191 adopt rules as needed to administer this section.
192 (5) ELIGIBILITY.--Eligibility to enroll in an approved
193 health flex plan is limited to residents of this state who:
194 (a)1. Are 64 years of age or younger;

CODING: Words stricken are deletions; words underlined are additions.

195 2. (b) Have a family income equal to or less than 200
196 percent of the federal poverty level;
197 (c) Are eligible under a federally approved Medicaid
198 demonstration waiver and reside in Palm Beach County or Miami-
199 Dade County;
200 3. (d) Are not covered by a private insurance policy and
201 are not eligible for coverage through a public health insurance
202 program, such as Medicare or Medicaid, unless specifically
203 authorized under paragraph (c), or another public health care
204 program, such as Kidcare, and have not been covered at any time
205 during the past 6 months, except that:
206 a. A person who was covered under an individual health
207 maintenance contract issued by a health maintenance organization
208 licensed under part I of chapter 641 that also was an approved
209 health flex plan on October 1, 2008, may apply for coverage in
210 the same health maintenance organization's health flex plan
211 without a lapse in coverage if all other eligibility
212 requirements are met; or
213 b. A person who was covered under Medicaid or Kidcare and
214 lost eligibility for the Medicaid or Kidcare subsidy due to
215 income restrictions within 90 days prior to applying for health
216 care coverage through an approved health flex plan may apply for
217 coverage in a health flex plan without a lapse in coverage if
218 all other eligibility requirements are met; and
219 4. (e) Have applied for health care coverage as an
220 individual through an approved health flex plan and have agreed
221 to make any payments required for participation, including

222 periodic payments or payments due at the time health care
223 services are provided; or
224 (b) Are part of an employer group at least 75 percent of
225 the employees of which have a family income equal to or less
226 than 300 percent of the federal poverty level and which employee
227 group is not covered by a private health insurance policy and
228 has not been covered at any time during the past 6 months. If
229 the health flex plan entity is a health insurer, health plan, or
230 health maintenance organization licensed under Florida law, only
231 50 percent of the employees must meet the income requirements
232 for the purpose of this paragraph.
233 (10) EXPIRATION. This section expires July 1, 2008.
234 Section 3. Section 408.9091, Florida Statutes, is created
235 to read:
236 408.9091 Cover Florida Health Care Access Program.--
237 (1) SHORT TITLE.--This section may be cited as the "Cover
238 Florida Health Care Access Program Act."
239 (2) LEGISLATIVE INTENT.--The Legislature finds that a
240 significant number of state residents are unable to obtain
241 affordable health insurance coverage. The Legislature also finds
242 that existing health flex plan coverage has had limited
243 participation due in part to narrow eligibility restrictions as
244 well as minimal benefit options for catastrophic and emergency
245 care coverage. Therefore, it is the intent of the Legislature to
246 expand the availability of health care options for uninsured
247 residents by developing an affordable health care product that
248 emphasizes coverage for basic and preventive health care
249 services; provides inpatient hospital, urgent, and emergency

250 care services; and is offered statewide by approved health
251 insurers, health maintenance organizations, health-care-
252 provider-sponsored organizations, or health care districts.
253 (3) DEFINITIONS.--As used in this section, the term:
254 (a) "Agency" means the Agency for Health Care
255 Administration.
256 (b) "Cover Florida plan" means a consumer choice benefit
257 plan approved under this section that guarantees payment or
258 coverage for specified benefits provided to an enrollee.
259 (c) "Cover Florida plan coverage" means health care
260 services that are covered as benefits under a Cover Florida
261 plan.
262 (d) "Cover Florida plan entity" means a health insurer,
263 health maintenance organization, health-care-provider-sponsored
264 organization, or health care district that develops and
265 implements a Cover Florida plan and is responsible for
266 administering the plan and paying all claims for Cover Florida
267 plan coverage by enrollees.
268 (e) "Cover Florida Plus" means a supplemental insurance
269 product, such as for additional catastrophic coverage or dental,
270 vision, or cancer coverage, approved under this section and
271 offered to all enrollees.
272 (f) "Enrollee" means an individual who has been determined
273 to be eligible for and is receiving health insurance coverage
274 under a Cover Florida plan.
275 (g) "Office" means the Office of Insurance Regulation of
276 the Financial Services Commission.

277 (4) PROGRAM.--The agency and the office shall jointly
278 establish and administer the Cover Florida Health Care Access
279 Program.
280 (a) General Cover Florida plan components must require
281 that:
282 1. Plans are offered on a guaranteed-issue basis to
283 enrollees, subject to exclusions for preexisting conditions
284 approved by the office and the agency.
285 2. Plans are portable such that the enrollee remains
286 covered regardless of employment status or the cost-sharing of
287 premiums.
288 3. Plans provide for cost containment through limits on
289 the number of services, caps on benefit payments, and copayments
290 for services.
291 4. A Cover Florida plan entity makes all benefit plan and
292 marketing materials available in English and Spanish.
293 5. In order to provide for consumer choice, Cover Florida
294 plan entities develop two alternative benefit option plans
295 having different cost and benefit levels, including at least one
296 plan that provides catastrophic coverage.
297 6. Plans without catastrophic coverage provide coverage
298 options for services including, but not limited to:
299 a. Preventive health services, including immunizations,
300 annual health assessments, well-woman and well-care services,
301 and preventive screenings such as mammograms, cervical cancer
302 screenings, and noninvasive colorectal or prostate screenings.
303 b. Incentives for routine preventive care.

304 c. Office visits for the diagnosis and treatment of
305 illness or injury.
306 d. Office surgery, including anesthesia.
307 e. Behavioral health services.
308 f. Durable medical equipment and prosthetics.
309 g. Diabetic supplies.
310 7. Plans providing catastrophic coverage, at a minimum,
311 provide coverage options for all of the services listed under
312 subparagraph 6.; however, such plans may include, but are not
313 limited to, coverage options for:
314 a. Inpatient hospital stays.
315 b. Hospital emergency care services.
316 c. Urgent care services.
317 d. Outpatient facility services, outpatient surgery, and
318 outpatient diagnostic services.
319 8. All plans offer prescription drug benefit coverage or
320 use a prescription drug manager such as the Florida Discount
321 Drug Card Program.
322 9. Plan enrollment materials provide information in plain
323 language on policy benefit coverage, benefit limits, cost-
324 sharing requirements, and exclusions and a clear representation
325 of what is not covered in the plan. The Cover Florida Health
326 Care Access Program shall require the following disclosure to be
327 reviewed and executed by all consumers purchasing program
328 options or insurance coverage through the program: "In
329 connection with the Cover Florida Health Care Access Program
330 authorized by s. 408.9091, Florida Statutes, agents and entities
331 offering products and services under the program shall inform

332 the named insured, applicant, or subscriber, on a form approved
333 by the Office of Insurance Regulation of the Financial Services
334 Commission, that the program is not an insurance program or, if
335 it is an insurance program, that benefits under the coverage are
336 limited under s. 408.9091, Florida Statutes, and that such
337 coverage is an alternative to coverage without such limitations.
338 If the form is signed by a named insured, applicant, or
339 subscriber, it shall be presumed that there was an informed,
340 knowing acceptance of such limitations."
341 10. Plans offered through a qualified employer meet the
342 requirements of s. 125 of the Internal Revenue Code.
343 (b) Guidelines shall be developed to ensure that Cover
344 Florida plans meet minimum standards for quality of care and
345 access to care. The agency shall ensure that the Cover Florida
346 plans follow standardized grievance procedures.
347 (c) Changes in Cover Florida plan benefits, premiums, and
348 policy forms are subject to regulatory oversight by the office
349 and the agency as provided under rules adopted by the Financial
350 Services Commission and the agency.
351 (d) The agency, the office, and the Executive Office of
352 the Governor shall develop a public awareness program to be
353 implemented throughout the state for the promotion of the Cover
354 Florida Health Care Access Program.
355 (e) Public or private entities may design programs to
356 encourage Floridians to participate in the Cover Florida Health
357 Care Access Program or to encourage employers to cosponsor some
358 share of Cover Florida plan premiums for employees.

359 (5) PLAN PROPOSALS.--The agency and the office shall
360 announce, no later than July 1, 2008, an invitation to negotiate
361 for Cover Florida plan entities to design a Cover Florida plan
362 proposal in which benefits and premiums are specified.
363 (a) The invitation to negotiate shall include guidelines
364 for the review of Cover Florida plan applications, policy forms,
365 and all associated forms and provide regulatory oversight of
366 Cover Florida plan advertisement and marketing procedures. A
367 plan shall be disapproved or withdrawn if the plan:
368 1. Contains any ambiguous, inconsistent, or misleading
369 provisions or any exceptions or conditions that deceptively
370 affect or limit the benefits purported to be assumed in the
371 general coverage provided by the plan;
372 2. Provides benefits that are unreasonable in relation to
373 the premium charged or contains provisions that are unfair or
374 inequitable, that are contrary to the public policy of this
375 state, that encourage misrepresentation, or that result in
376 unfair discrimination in sales practices;
377 3. Cannot demonstrate that the plan is financially sound
378 and that the applicant is able to underwrite or finance the
379 health care coverage provided;
380 4. Cannot demonstrate that the applicant and its
381 management are in compliance with the standards required under
382 s. 624.404(3); or
383 5. Does not guarantee that enrollees may participate in
384 the Cover Florida plan entity's comprehensive network of
385 providers, as determined by the office, the agency, and the
386 contract.

387 (b) The agency and the office may announce an invitation
388 to negotiate for companies that offer supplemental insurance or
389 discount medical plans that are licensed under part II of
390 chapter 636 to design Cover Florida Plus products.
391 (c) The agency and office shall approve at least one Cover
392 Florida plan entity having an existing statewide network of
393 providers and may approve at least one regional network plan in
394 each existing Medicaid area.
395 (6) LICENSE NOT REQUIRED.--
396 (a) The licensing requirements of the Florida Insurance
397 Code and chapter 641 relating to health maintenance
398 organizations do not apply to a Cover Florida plan approved
399 under this section unless expressly made applicable. However,
400 for the purpose of prohibiting unfair trade practices, Cover
401 Florida plans are considered to be insurance subject to the
402 applicable provisions of part IX of chapter 626 except as
403 otherwise provided in this section.
404 (b) Cover Florida plans are not covered by the Florida
405 Life and Health Insurance Guaranty Association under part III of
406 chapter 631 or by the Health Maintenance Organization Consumer
407 Assistance Plan under part IV of chapter 631.
408 (7) ELIGIBILITY.--Eligibility to enroll in a Cover Florida
409 plan is limited to residents of this state who meet all of the
410 following requirements:
411 (a) Are between 19 and 64 years of age, inclusive.
412 (b) Are not covered by a private insurance policy and are
413 not eligible for coverage through a public health insurance
414 program, such as Medicare, Medicaid, or Kidcare, unless

415 eligibility for coverage lapses due to no longer meeting income
416 or categorical requirements.
417 (c) Have not been covered by any health insurance program
418 at any time during the past 6 months, unless coverage under a
419 health insurance program was terminated within the previous 6
420 months due to:
421 1. Loss of a job that provided an employer-sponsored
422 health benefit plan;
423 2. Exhaustion of coverage that was continued under COBRA
424 or continuation-of-coverage requirements under s. 627.6692;
425 3. Reaching the limiting age under the policy; or
426 4. Death of, or divorce from, a spouse who was provided an
427 employer-sponsored health benefit plan.
428 (d) Have applied for health care coverage through a Cover
429 Florida plan and have agreed to make any payments required for
430 participation, including periodic payments or payments due at
431 the time health care services are provided.
432 (8) RECORDS.--Each Cover Florida plan must maintain
433 enrollment data and provide network data and reasonable records
434 to enable the office and the agency to monitor plans and to
435 determine the financial viability of the Cover Florida plan, as
436 necessary.
437 (9) NONENTITLEMENT.--Coverage under a Cover Florida plan
438 is not an entitlement, and a cause of action does not arise
439 against the state, a local government entity, any other
440 political subdivision of the state, or the agency or the office
441 for failure to make coverage available to eligible persons under
442 this section.

443 (10) PROGRAM EVALUATION.--The agency and the office shall:
444 (a) Evaluate the Cover Florida Health Care Access Program
445 and its effect on the entities that seek approval as Cover
446 Florida plans, on the number of enrollees, and on the scope of
447 the health care coverage offered under a Cover Florida plan.
448 (b) Provide an assessment of the Cover Florida plans and
449 their potential applicability in other settings.
450 (c) Use Cover Florida plans to gather more information to
451 evaluate low-income, consumer-driven benefit packages.
452 (d) Jointly submit by March 1, 2009, and annually
453 thereafter, a report to the Governor, the President of the
454 Senate, and the Speaker of the House of Representatives that
455 provides the information specified in paragraphs (a)-(c) and
456 recommendations relating to the successful implementation and
457 administration of the program.
458 (11) RULEMAKING AUTHORITY.--The agency and the Financial
459 Services Commission may adopt rules pursuant to ss. 120.536(1)
460 and 120.54 as needed to administer this section.
461 Section 4. Section 408.910, Florida Statutes, is created
462 to read:
463 408.910 Florida Health Choices Program.--
464 (1) LEGISLATIVE INTENT.--The Legislature finds that a
465 significant number of the residents of this state do not have
466 adequate access to affordable, quality health care. The
467 Legislature further finds that increasing access to affordable,
468 quality health care will be best accomplished by establishing a
469 competitive market for purchasing health insurance and health

470 services. It is therefore the intent of the Legislature to
471 create the Florida Health Choices Program to:
472 (a) Expand opportunities for Floridians to purchase
473 affordable health insurance and health services.
474 (b) Preserve the benefits of employment-sponsored
475 insurance while easing the administrative burden for employers
476 who offer these benefits.
477 (c) Enable individual choice in both the manner and amount
478 of health care purchased.
479 (d) Provide for the purchase of individual, portable
480 health care coverage.
481 (e) Disseminate information to consumers on the price and
482 quality of health services.
483 (f) Sponsor a competitive market that stimulates product
484 innovation, quality improvement, and efficiency in the
485 production and delivery of health services.
486 (2) DEFINITIONS.--As used in this section:
487 (a) "Corporation" means the Florida Health Choices, Inc.,
488 established under this section.
489 (b) "Health insurance agent" means an agent licensed under
490 part IV of chapter 626.
491 (c) "Insurer" means an individual health insurance policy
492 subject to this chapter, an insurer issuing a group health
493 insurance policy or certificate pursuant to s. 627.651, a plan
494 of self-insurance providing health coverage benefits to
495 residents of this state pursuant to s. 627.651, an insurer
496 delivering a group health policy issued or delivered outside
497 this state under which a resident of this state is provided

498 coverage pursuant to s. 627.6515, a preferred provider
499 organization as defined in s. 627.6471, or an exclusive provider
500 organization as defined in s. 627.6472.
501 (d) "Program" means the Florida Health Choices Program
502 established by this section.
503 (3) PROGRAM PURPOSE AND COMPONENTS.--The Florida Health
504 Choices Program is created as a single, centralized market for
505 the sale and purchase of various products that enable
506 individuals to pay for health care. These products include, but
507 are not limited to, health insurance plans, health maintenance
508 organization plans, prepaid services, service contracts, and
509 flexible spending accounts. The components of the program
510 include:
511 (a) Enrollment of employers.
512 (b) Administrative services for participating employers,
513 including:
514 1. Assistance in seeking federal approval of cafeteria
515 plans.
516 2. Collection of premiums and other payments.
517 3. Management of individual benefit accounts.
518 4. Distribution of premiums to insurers and payments to
519 other eligible vendors.
520 5. Assistance for participants in complying with reporting
521 requirements.
522 (c) Services to individual participants, including:
523 1. Information about available products and participating
524 vendors.

525 2. Assistance to participating individuals for assessing
526 the benefits and limits of each product, including information
527 necessary to distinguish between policies offering creditable
528 coverage and other products available through the program.
529 3. Account information to assist individual participants
530 to manage available resources.
531 4. Services that promote healthy behaviors.
532 (d) Recruitment of vendors, including insurers, health
533 maintenance organizations, prepaid clinic service providers,
534 provider service networks, and other providers.
535 (e) Certification of vendors to ensure capability,
536 reliability, and validity of offerings.
537 (f) Collection of data, monitoring, assessment, and
538 reporting of vendor performance.
539 (g) Information services for individuals and employers.
540 (h) Program evaluation.
541 (4) ELIGIBILITY AND PARTICIPATION.--Participation in the
542 program is voluntary and shall be available to employers,
543 individuals, vendors, and health insurance agents as specified
544 in this subsection.
545 (a) Employers eligible to enroll in the program include:
546 1. Employers with 1 to 50 employees.
547 2. Fiscally constrained counties described in s. 218.67.
548 3. Municipalities with populations of fewer than 50,000
549 residents.
550 4. School districts in fiscally constrained counties.
551 (b) Individuals eligible to participate in the program
552 include:

553 1. Individual employees of enrolled employers.
554 2. State employees not eligible for state employee health
555 benefits.
556 3. State retirees.
557 4. Medicaid reform participants who select the opt-out
558 provision of reform.
559 5. Statutory rural hospitals.
560 (c) Employers who choose to participate in the program may
561 enroll by complying with the procedures established by the
562 corporation. These procedures shall include, but not be limited
563 to, the following:
564 1. Submission of required information.
565 2. Compliance with federal tax requirements for the
566 establishment of a cafeteria plan, pursuant to s. 125 of the
567 Internal Revenue Code, including designation of the employer's
568 plan as a premium payment plan, a salary reduction plan with
569 flexible spending arrangements, or a salary reduction plan with
570 a premium payment and flexible spending arrangements.
571 3. Determination of the employer's contribution, if any,
572 per employee, provided that such contribution is equal for each
573 eligible employee.
574 4. Establishment of payroll deduction procedures, subject
575 to the agreement of each individual employee who voluntarily
576 participates in the program.
577 5. Designation of the corporation as the third-party
578 administrator for the employer's health benefit plan.
579 6. Identification of eligible employees.
580 7. Arrangement for periodic payments.

581 (d) Eligible vendors and the products and services that
582 they are permitted to sell are as follows:
583 1. Insurers licensed under chapter 627 may sell health
584 insurance policies, limited benefit policies, other risk-bearing
585 coverage, and other products or services.
586 2. Health maintenance organizations licensed under part I
587 of chapter 641 may sell health insurance policies, limited
588 benefit policies, other risk-bearing products, and other
589 products or services.
590 3. Prepaid health clinic service providers licensed under
591 part II of chapter 641 may sell prepaid service contracts and
592 other arrangements for a specified amount and type of health
593 services or treatments.
594 4. Out-of-state insurers may sell health insurance
595 policies, limited benefit policies, other risk-bearing products,
596 and other products or services.
597 5. Health care providers, including hospitals and other
598 licensed health facilities, health care clinics, licensed health
599 professionals, pharmacies, and other licensed health care
600 providers, may sell service contracts and arrangements for a
601 specified amount and type of health services or treatments.
602 6. Provider organizations, including service networks,
603 group practices, professional associations, and other
604 incorporated organizations of providers, may sell service
605 contracts and arrangements for a specified amount and type of
606 health services or treatments.
607 7. Corporate entities providing specific health services
608 in accordance with applicable state law may sell service

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609 contracts and arrangements for a specified amount and type of
610 health services or treatments.
611
612 Otherwise eligible vendors may be excluded from participating in
613 the program for deceptive or predatory practices, financial
614 insolvency, or failure to comply with the terms of the
615 participation agreement or other standards set by the
616 corporation.
617 (e) Eligible individuals may voluntarily continue
618 participation in the program regardless of subsequent changes in
619 job status or Medicaid eligibility. Individuals who join the
620 program may participate by complying with the procedures
621 established by the corporation. These procedures shall include,
622 but are not limited to:
623 1. Submission of required information.
624 2. Authorization for payroll deduction.
625 3. Compliance with federal tax requirements.
626 4. Arrangements for payment in the event of job changes.
627 5. Selection of products and services.
628 (f) Vendors who choose to participate in the program may
629 enroll by complying with the procedures established by the
630 corporation. These procedures shall include, but are not limited
631 to:
632 1. Submission of required information, including a
633 complete description of the coverage, services, provider
634 network, payment restrictions, and other requirements of each
635 product offered through the program.

636 2. Execution of an agreement to make all products offered
637 through the program available to all individual participants.
638 3. Establishment of product prices based on age, gender,
639 and location of the individual participant.
640 4. Arrangements for receiving payment for enrolled
641 participants.
642 5. Participation in ongoing reporting processes
643 established by the corporation.
644 6. Compliance with grievance procedures established by the
645 corporation.
646 (g) Health insurance agents licensed under part IV of
647 chapter 626 are eligible to voluntarily participate as buyers'
648 representatives. A buyer's representative acts on behalf of an
649 individual purchasing health insurance and health services
650 through the program by providing information about products and
651 services available through the program and assisting the
652 individual with both the decision and the procedure of selecting
653 specific products. Serving as a buyer's representative does not
654 constitute a conflict of interest with continuing
655 responsibilities as a health insurance agent provided the
656 relationship between each agent and any participating vendor is
657 disclosed prior to advising an individual participant about the
658 products and services available through the program. In order to
659 participate, a health insurance agent shall comply with the
660 procedures established by the corporation, including:
661 1. Completion of training requirements.
662 2. Execution of a participation agreement specifying the
663 terms and conditions of participation.

664 3. Disclosure of any appointments to solicit insurance or
665 procure applications for vendors participating in the program.
666 4. Arrangements to receive payment from the corporation
667 for services as a buyer's representative.
668 (5) PRODUCTS.--
669 (a) The products that may be made available for purchase
670 through the program include, but are not limited to:
671 1. Health insurance policies.
672 2. Limited benefit plans.
673 3. Prepaid clinic services.
674 4. Service contracts.
675 5. Arrangements for purchase of specific amounts and types
676 of health services and treatments.
677 6. Flexible spending accounts.
678 (b) Health insurance policies, limited benefit plans,
679 prepaid service contracts, and other contracts for services must
680 ensure the availability of covered services and benefits to
681 participating individuals for at least 1 full enrollment year.
682 (c) Products may be offered for multiyear periods provided
683 the price of the product is specified for the entire period or
684 for each separately priced segment of the policy or contract.
685 (d) The corporation shall require the following disclosure
686 to be reviewed and executed by all consumers purchasing program
687 options or insurance coverage through the corporation: "In
688 connection with the Florida Health Choices Program authorized by
689 s. 408.910, Florida Statutes, agents and entities offering
690 products and services under the program shall inform the named
691 insured, applicant, or subscriber, on a form approved by the

692 Office of Insurance Regulation of the Financial Services
693 Commission, that the products and services are not insurance or,
694 if they are insurance, that benefits under the coverage are
695 limited under s. 408.910, Florida Statutes, and that such
696 coverage is an alternative to coverage without such limitations.
697 If the form is signed by a named insured, applicant, or
698 subscriber, it shall be presumed that there was an informed,
699 knowing acceptance of such limitations."
700 (6) PRICING.--Prices for the products sold through the
701 program shall be transparent to participants and established by
702 the vendors based on age, gender, and location of participants.
703 Prior to making the product available to individual
704 participants, the corporation shall ensure that the prices are
705 analyzed to compare the expected health care costs for the
706 covered services and benefits to the vendor's price for that
707 coverage. The results shall be reported to individuals
708 participating in the program. Once established, the price set by
709 the vendor must remain in force for at least 1 year and may only
710 be redetermined by the vendor at the next annual enrollment
711 period. The corporation shall annually set a load factor to each
712 premium or price set by a participating vendor. This surcharge
713 may not be more than 2.5 percent of the price and shall be used
714 to generate funding for administrative services provided by the
715 corporation and payments to buyers' representatives.
716 (7) EXCHANGE PROCESS.--The program shall provide a single,
717 centralized market for purchase of health insurance and health
718 services. Purchases may be made by participating individuals
719 over the Internet or through the services of a participating

720 health insurance agent. Information about each product and
721 service available through the program shall be made available
722 through printed material and an interactive Internet website. A
723 participant needing personal assistance to select products and
724 services shall be referred to a participating agent in his or
725 her area.
726 (a) Participation in the program may begin at any time
727 during a year when the employer completes enrollment and meets
728 the requirements specified by the corporation pursuant to
729 paragraph (4)(c).
730 (b) Initial selection of products and services must be
731 made by an individual participant within 60 days after the date
732 on which the individual's employer qualified for participation.
733 An individual who fails to enroll in products and services by
734 the end of this period shall be limited to participation in
735 flexible spending account services until the next annual
736 enrollment period.
737 (c) Initial enrollment periods for each product selected
738 by an individual participant must last a minimum of 12 months,
739 unless the individual participant specifically agrees to a
740 different enrollment period.
741 (d) When an individual has selected one or more products
742 and enrolled in those products for at least 12 months or any
743 other period specifically agreed to by the individual
744 participant, changes in selected products and services may only
745 be made during the annual enrollment period established by the
746 corporation.

747 (e) The limits established in paragraphs (b)-(d) apply to
748 any risk-bearing product that promises future payment or
749 coverage for a variable amount of benefits or services. The
750 limits do not apply to initiation of flexible spending plans
751 when those plans are not associated with specific high-
752 deductible insurance policies or to the use of spending accounts
753 for any products offering individual participants specific
754 amounts and types of health services and treatments at a
755 contracted price.
756 (8) RISK POOLING.--The program shall utilize methods for
757 pooling the risk of individual participants and preventing
758 selection bias. These methods shall include, but not be limited
759 to, a postenrollment risk adjustment of the premium payments to
760 the vendors. The corporation shall establish a methodology for
761 assessing the risk of enrolled individual participants based on
762 data reported by the vendors about their enrollees. Monthly
763 distributions of payments to the vendors shall be adjusted based
764 on the assessed relative risk profile of the enrollees in each
765 risk-bearing product for the most recent period for which data
766 is available.
767 (9) EXEMPTIONS.--
768 (a) Policies sold as part of the program are not subject
769 to the licensing requirements of the Florida Insurance Code,
770 chapter 641, or the mandated offerings or coverages established
771 in part VI of chapter 627 and chapter 641.
772 (b) The corporation is authorized to act as an
773 administrator as defined in s. 626.88. However, the corporation

774 is not subject to the licensing requirements of part VII of
775 chapter 626.
776 (10) LIQUIDATION OR DISSOLUTION.--The Department of
777 Financial Services shall supervise any liquidation or
778 dissolution of the corporation and shall have, with respect to
779 such liquidation or dissolution, all power granted to it
780 pursuant to the Florida Insurance Code.
781 (11) CORPORATION.--There is created the Florida Health
782 Choices, Inc., which shall be registered, incorporated,
783 organized, and operated in compliance with chapter 617. The
784 purpose of the corporation is to administer the program created
785 in this section and to conduct such other business as may
786 further the administration of the program.
787 (a) The corporation shall be governed by a board of
788 directors consisting of 15 individuals appointed in the
789 following manner:
790 1. Five members appointed by and serving at the pleasure
791 of the Governor, consisting of:
792 a. The Secretary of Health Care Administration or a
793 designee with expertise in health care services.
794 b. The Secretary of Management Services or a designee with
795 expertise in state employee benefits.
796 c. Three representatives of eligible public employers.
797 2. Five members appointed by and serving at the pleasure
798 of the President of the Senate, consisting of representatives of
799 employers, insurers, health care providers, health insurance
800 agents, and individual participants.

801 3. Five members appointed by and serving at the pleasure
802 of the Speaker of the House of Representatives, consisting of
803 representatives of employers, insurers, health care providers,
804 health insurance agents, and individual participants.
805 (b) Members shall be appointed for terms of up to 3 years.
806 Any member is eligible for reappointment. A vacancy on the board
807 shall be filled for the unexpired portion of the term in the
808 same manner as the original appointment.
809 (c) The board shall select a chief executive officer for
810 the corporation who shall be responsible for the selection of
811 such other staff as may be authorized by the corporation's
812 operating budget as adopted by the board.
813 (d) Board members are entitled to receive, from funds of
814 the corporation, reimbursement for per diem and travel expenses
815 as provided by s. 112.061. No other compensation is authorized.
816 (e) There shall be no liability on the part of, and no
817 cause of action shall arise against, any member of the board or
818 its employees or agents for any action taken by them in the
819 performance of their powers and duties under this section.
820 (f) The board shall develop and adopt bylaws and other
821 corporate procedures as necessary for the operation of the
822 corporation and carrying out the purposes of this section. The
823 bylaws shall specify procedures for selection of officers and
824 qualifications for reappointment, provided that no board member
825 shall serve more than 8 consecutive years. The bylaws shall also
826 require an annual membership meeting that provides an
827 opportunity for input and interaction with individual
828 participants in the program.

829 (g) The corporation may exercise all powers granted to it
830 under chapter 617 necessary to carry out the purposes of this
831 section, including, but not limited to, the power to receive and
832 accept grants, loans, or advances of funds from any public or
833 private agency and to receive and accept from any source
834 contributions of money, property, labor, or any other thing of
835 value to be held, used, and applied for the purposes of this
836 section.
837 (h) The corporation shall:
838 1. Determine eligibility of employers, vendors,
839 individuals, and agents in accordance with subsection (4).
840 2. Establish procedures necessary for the operation of the
841 program, including, but not limited to, procedures for
842 application, enrollment, risk assessment, risk adjustment, plan
843 administration, performance monitoring, and consumer education.
844 3. Arrange for collection of contributions from
845 participating employers and individuals.
846 4. Arrange for payment of premiums and other appropriate
847 disbursements based on the selections of products and services
848 by the individual participants.
849 5. Establish criteria for disenrollment of participating
850 individuals based on failure to pay the individual's share of
851 any contribution required to maintain enrollment in selected
852 products.
853 6. Establish criteria for exclusion of vendors pursuant to
854 paragraph (4)(d).
855 7. Develop and implement a plan for promoting public
856 awareness of and participation in the program.

857 8. Secure staff and consultant services necessary to the
858 operation of the program.
859 9. Establish policies and procedures regarding
860 participation in the program for individuals, vendors, health
861 insurance agents, and employers.
862 10. Develop a plan, in coordination with the Department of
863 Revenue, to establish tax credits or refunds for employers that
864 participate in the program. The corporation shall submit the
865 plan to the Governor, the President of the Senate, and the
866 Speaker of the House of Representatives no later than January 1,
867 2009.
868 11. Beginning in fiscal year 2009-2010, submit by February
869 1 an annual report to the Governor, the President of the Senate,
870 and the Speaker of the House of Representatives documenting the
871 corporation's activities in compliance with the duties
872 delineated in this section.
873 (i) To ensure program integrity and to safeguard the
874 financial transactions made under the auspices of the program,
875 the corporation is authorized to establish qualifying criteria
876 and certification procedures for vendors, require performance
877 bonds or other guarantees of ability to complete contractual
878 obligations, monitor the performance of vendors, and enforce the
879 agreements of the program through financial penalty or
880 disqualification from the program.
881 Section 5. Subsection (22) of section 409.811, Florida
882 Statutes, is amended to read:
883 409.811 Definitions relating to Florida Kidcare Act.--As
884 used in ss. 409.810-409.820, the term:

885 (22) "Premium assistance payment" means the monthly
886 consideration paid by the agency per enrollee in the Florida
887 Kidcare program towards health insurance premiums and may
888 include the direct payment of the premium for a qualifying child
889 to be covered as a dependent under an employer-sponsored group
890 family plan when such payment does not exceed the payment
891 required for an enrollee in the Florida Kidcare program.
892 Section 6. Section 624.1265, Florida Statutes, is created
893 to read:
894 624.1265 Nonprofit religious organization exemption;
895 authority; notice.--
896 (1) Any nonprofit religious organization that qualifies
897 under Title 26, s. 501 of the Internal Revenue Code of 1986, as
898 amended; that limits its participants to members of the same
899 religion; that acts as an organizational clearinghouse for
900 information between participants who have financial, physical,
901 or medical needs and participants with the ability to pay for
902 the benefit of those participants with financial, physical, or
903 medical needs; that provides for the financial or medical needs
904 of a participant through payments directly from one participant
905 to another; and that suggests amounts that participants may
906 voluntarily give with no assumption of risk or promise to pay
907 either among the participants or between the participants and
908 the organization are not subject to any requirements of the
909 Florida Insurance Code.
910 (2) Nothing in this section prevents the organization
911 described in subsection (1) from establishing qualifications of
912 participation relating to the health of a prospective

913 participant, prevents a participant from limiting the financial
914 or medical needs that may be eligible for payment, or prevents
915 the organization from canceling the membership of a participant
916 when such participant indicates his or her unwillingness to
917 participate by failing to make a payment to another participant
918 for a period in excess of 60 days.
919 (3) The organization described in subsection (1) shall
920 provide each prospective participant in the organizational
921 clearinghouse written notice that the organization is not an
922 insurance company, that membership is not offered through an
923 insurance company, and that the organization is not subject to
924 the regulatory requirements or consumer protections of the
925 Florida Insurance Code.
926 Section 7. Paragraph (c) of subsection (1) of section
927 627.602, Florida Statutes, is amended to read:
928 627.602 Scope, format of policy.--
929 (1) Each health insurance policy delivered or issued for
930 delivery to any person in this state must comply with all
931 applicable provisions of this code and all of the following
932 requirements:
933 (c) The policy may purport to insure only one person,
934 except that upon the application of an adult member of a family,
935 who is deemed to be the policyholder, a policy may insure,
936 either originally or by subsequent amendment, any eligible
937 members of that family, including husband, wife, any children or
938 any person dependent upon the policyholder. If an insurer offers
939 coverage that insures dependent children of the policyholder,
940 the policy must comply with s. 627.6562.

941 Section 8. Subsection (4) of section 627.653, Florida
942 Statutes, is renumbered as subsection (5), and a new subsection
943 (4) is added to that section to read:
944 627.653 Employee groups.--
945 (4) Unless the employer chooses otherwise, for all
946 policies issued or renewed after October 1, 2008, all eligible
947 employees and their dependents shall be enrolled for coverage at
948 the time of issuance or during the next open or special
949 enrollment period, unless the employee provides written notice
950 to the employer declining coverage, which notice shall include
951 evidence of coverage under an existing group insurance policy or
952 group health benefit plan or other reasons for declining
953 coverage. Such notice shall be retained by the employer as part
954 of the employee's employment or insurance file. An employer may
955 require its employees to participate in its group health plan as
956 a condition of employment. This subsection shall apply to all
957 individual, group, blanket, and franchise health insurance
958 policies and health maintenance contracts issued, renewed, or
959 amended after October 1, 2008.
960 Section 9. Section 627.6562, Florida Statutes, is amended
961 to read:
962 627.6562 Dependent coverage.--
963 (1) If an insurer offers, under a group, blanket, or
964 franchise health insurance policy, coverage that insures
965 dependent children of the policyholder or certificateholder, the
966 policy must insure a dependent child of the policyholder or
967 certificateholder at least until the end of the calendar year in

968 which the child reaches the age of 30 ~~25,~~ if the child ~~meets all~~
969 ~~of the following~~:
970 (a) Is unmarried and is a dependent as defined in the
971 Federal Tax Code ~~The child is dependent upon the policyholder or~~
972 ~~certificateholder for support~~.
973 (b) Is a resident of this state ~~The child is living in the~~
974 ~~household of the policyholder or certificateholder, or the child~~
975 ~~is a full-time or part-time student~~.
976 (c) Is not provided coverage as a named subscriber,
977 insured, enrollee, or covered person under any other group,
978 blanket, or franchise health insurance policy or individual
979 health benefit plan or entitled to benefits under Title XVIII of
980 the Social Security Act, Pub. L. No. 89-97, 42 U.S.C. ss. 1395
981 et seq.
982 (d) Is not eligible for coverage as an employee under an
983 employer sponsored health plan.
984 (2) ~~Nothing in~~ This section does not:
985 (a) Affect or preempt ~~affects or preempts~~ an insurer's
986 right to medically underwrite or charge the appropriate premium.
987 (b) Require coverage for services provided to a dependent
988 before October 1, 2008.
989 (c) Require an employer to pay all or part of the cost of
990 coverage provided for a dependent under this section.
991 (d) Prohibit an insurer or health maintenance organization
992 from increasing the limiting age for dependent coverage to age
993 30 in policies or contracts issued or renewed prior to the
994 effective date of this act.

995 (3) Until April 1, 2009, a dependent child who qualifies
996 for coverage under subsection (1) but whose coverage as a
997 dependent child under a covered person's plan terminated under
998 the terms of the plan before October 1, 2008, may make a written
999 election to reinstate coverage, without proof of insurability,
1000 under that plan as a dependent child pursuant to this section.
1001 All other dependent children who qualify for coverage under
1002 subsection (1) shall be automatically covered at least until the
1003 end of the calendar year in which the child reaches the age of
1004 30, unless the covered person provides the group policyholder
1005 with written evidence the dependent child is married, is not a
1006 resident of the state, is covered under a separate comprehensive
1007 health insurance policy or a health benefit plan, is entitled to
1008 benefits under Title XVIII of the Social Security Act, Pub. L.
1009 No. 89-97, 42 U.S.C. ss. 1935 et seq., or is eligible for
1010 coverage as an employee under an employer-sponsored health plan.
1011 (4) The covered person's plan may require the payment of a
1012 premium by the covered person or dependent child, as
1013 appropriate, subject to the approval of the Office of Insurance
1014 Regulation, for any period of coverage relating to a dependent's
1015 written election for coverage pursuant to subsection (3).
1016 (5) Notice regarding the reinstatement of coverage for a
1017 dependent child as provided under this section must be provided
1018 to a covered person in the certificate of coverage prepared for
1019 covered persons by the insurer or by the covered person's
1020 employer. The notice shall be given as soon as practicable after
1021 July 1, 2008, and such notice may be given through the group
1022 policyholder.

1023 (6) This section does not apply to accident only,
1024 specified disease, disability income, Medicare supplement, or
1025 long-term care insurance policies.
1026 (7) This section applies to all group, blanket, and
1027 franchise health insurance policies covering residents of this
1028 state, including, but not limited to, policies in which the
1029 carrier has reserved the right to change the premium. This
1030 section applies to all individual, group, blanket, and franchise
1031 health insurance policies and health maintenance contracts
1032 issued, renewed, or amended after October 1, 2008.
1033 Section 10. Paragraph (h) of subsection (5) of section
1034 627.6699, Florida Statutes, is amended to read:
1035 627.6699 Employee Health Care Access Act.--
1036 (5) AVAILABILITY OF COVERAGE.--
1037 (h) All health benefit plans issued under this section
1038 must comply with the following conditions:
1039 1. For employers who have fewer than two employees, a late
1040 enrollee may be excluded from coverage for no longer than 24
1041 months if he or she was not covered by creditable coverage
1042 continually to a date not more than 63 days before the effective
1043 date of his or her new coverage.
1044 2. Any requirement used by a small employer carrier in
1045 determining whether to provide coverage to a small employer
1046 group, including requirements for minimum participation of
1047 eligible employees and minimum employer contributions, must be
1048 applied uniformly among all small employer groups having the
1049 same number of eligible employees applying for coverage or
1050 receiving coverage from the small employer carrier, except that

1051 a small employer carrier that participates in, administers, or
1052 issues health benefits pursuant to s. 381.0406 which do not
1053 include a preexisting condition exclusion may require as a
1054 condition of offering such benefits that the employer has had no
1055 health insurance coverage for its employees for a period of at
1056 least 6 months. A small employer carrier may vary application of
1057 minimum participation requirements and minimum employer
1058 contribution requirements only by the size of the small employer
1059 group.
1060 3. Unless the employer chooses otherwise, for all policies
1061 or health maintenance contracts issued or renewed after October
1062 1, 2008, all eligible employees and their dependents shall be
1063 enrolled for coverage at the time of issuance or during the next
1064 open or special enrollment period, unless the employee provides
1065 written notice to the employer declining coverage, which notice
1066 shall include evidence of coverage under an existing group
1067 insurance policy or group health benefit plan or other reasons
1068 for declining coverage. Such notice shall be retained by the
1069 employer as part of the employee's employment or insurance file.
1070 An employer may require its employees to participate in its
1071 group health plan as a condition of employment.
1072 4.~~3.~~ In applying minimum participation requirements with
1073 respect to a small employer, a small employer carrier shall not
1074 consider as an eligible employee employees or dependents who
1075 have qualifying existing coverage in an employer-based group
1076 insurance plan or an ERISA qualified self-insurance plan in
1077 determining whether the applicable percentage of participation
1078 is met. However, a small employer carrier may count eligible

1079 employees and dependents who have coverage under another health
1080 plan that is sponsored by that employer.
1081 5.~~4.~~ A small employer carrier shall not increase any
1082 requirement for minimum employee participation or any
1083 requirement for minimum employer contribution applicable to a
1084 small employer at any time after the small employer has been
1085 accepted for coverage, unless the employer size has changed, in
1086 which case the small employer carrier may apply the requirements
1087 that are applicable to the new group size.
1088 6.~~5.~~ If a small employer carrier offers coverage to a
1089 small employer, it must offer coverage to all the small
1090 employer's eligible employees and their dependents. A small
1091 employer carrier may not offer coverage limited to certain
1092 persons in a group or to part of a group, except with respect to
1093 late enrollees.
1094 7.~~6.~~ A small employer carrier may not modify any health
1095 benefit plan issued to a small employer with respect to a small
1096 employer or any eligible employee or dependent through riders,
1097 endorsements, or otherwise to restrict or exclude coverage for
1098 certain diseases or medical conditions otherwise covered by the
1099 health benefit plan.
1100 8.~~7.~~ An initial enrollment period of at least 30 days must
1101 be provided. An annual 30-day open enrollment period must be
1102 offered to each small employer's eligible employees and their
1103 dependents. A small employer carrier must provide special
1104 enrollment periods as required by s. 627.65615.
1105 Section 11. Subsections (41) and (42) are added to section
1106 641.31, Florida Statutes, to read:

1107 641.31 Health maintenance contracts.--
1108 (41) Unless the employer chooses otherwise, for all
1109 policies or health maintenance contracts issued or renewed after
1110 October 1, 2008, all eligible employees and their dependents
1111 shall be enrolled for coverage at the time of issuance or during
1112 the next open or special enrollment period, unless the employee
1113 provides written notice to the employer declining coverage,
1114 which notice shall include evidence of coverage under an
1115 existing group insurance policy or group health benefit plan or
1116 other reasons for declining coverage. Such notice shall be
1117 retained by the employer as part of the employee's employment or
1118 insurance file. An employer may require its employees to
1119 participate in its group health plan as a condition of
1120 employment. This subsection shall apply to all individual,
1121 group, blanket, and franchise health insurance policies and
1122 health maintenance contracts issued, renewed, or amended after
1123 October 1, 2008.
1124 (42) All health maintenance contracts that provide
1125 coverage for a member of the family of the subscriber shall
1126 comply with s. 627.6562.
1127 Section 12. Subsections (1), (4), and (6) of section
1128 641.402, Florida Statutes, are amended to read:
1129 641.402 Definitions.--As used in this part, the term:
1130 (1) "Basic services" includes any of the following:
1131 limited hospital inpatient services, which may include hospital
1132 inpatient physician services, up to a maximum of coverage
1133 benefit of 5 days and a maximum dollar amount of coverage of
1134 $15,000 per calendar year; emergency care;~~,~~ physician care other

1135 than hospital inpatient physician services;, ambulatory
1136 diagnostic treatment;, and preventive health care services.
1137 (4) "Prepaid health clinic" means any organization
1138 authorized under this part which provides, either directly or
1139 through arrangements with other persons, basic services to
1140 persons enrolled with such organization, on a prepaid per capita
1141 or prepaid aggregate fixed-sum basis, including those basic
1142 services described in this part which subscribers might
1143 reasonably require to maintain good health. However, no clinic
1144 that provides or contracts for, either directly or indirectly,
1145 inpatient hospital services, hospital inpatient physician
1146 services, or indemnity against the cost of such services shall
1147 be a prepaid health clinic.
1148 (6) "Provider" means any physician or person other than a
1149 hospital that furnishes health care services under this part and
1150 is licensed or authorized to practice in this state.
1151 Section 13. This act shall take effect upon becoming a
1152 law.