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 of 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invitation to negotiate to include certain guidelines; providing certain conditions in which plans are disapproved or withdrawn; authorizing the agency and the office to announce an invitation to negotiate for companies that offer supplemental insurance or discount medical plans;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; creating s. 408.910, F.S.; establishing the Florida Health Choices Program; providing legislative intent; providing definitions; providing program purpose and components; providing employer eligibility criteria; providing individual eligibility criteria; providing employer enrollment criteria; providing vendor, product, and service eligibility criteria; providing for individual participation regardless of subsequent job status or

Medicaid eligibility; providing vendor enrollment criteria; providing for participation by health insurance agents; providing criteria for products available for purchase; providing criteria for product pricing; providing for an administrative surcharge; providing for an exchange process; providing for enrollment periods and changes in selected products; requiring the corporation to establish a website to provide information about products and services; providing methods for the pooling of risk; providing for exemptions from certain statutory provisions, mandated offerings and coverages, and licensing requirements; providing for administrators; creating the Florida Health Choices, Inc.; requiring the department to supervise any liquidation or dissolution of the corporation; providing for corporate governance and board membership and terms; providing for reimbursement for per diem and travel expenses; providing for powers and duties of the corporation; requiring the corporation to coordinate with the Department of Revenue to develop a plan by January 1, 2009, for creating tax exemptions or refunds for participating in the program; requiring the corporation to submit an annual report to the Governor and Legislature; authorizing the corporation to establish and enforce certain program integrity measures; 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; creating s. 624.1265, F.S.; exempting certain nonprofit religious organizations from requirements of the Florida

Insurance Code; preserving certain authority of such organizations; requiring such organizations to provide certain notice to prospective participants; providing notice requirements; amending s. 624.91, F.S.; revising the duties of the Florida Healthy Kids Corporation; amending s. 627.602, F.S.; requiring that individual health insurance policies insuring dependent children of a policyholder comply with certain provisions of state law; amending s. 627.6562, F.S.; requiring group health 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. 641.31, F.S.; requiring that health maintenance organization contracts providing coverage for a member of the subscriber's family to comply with certain provisions of state law; providing an appropriation; 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)1. Are 64 years of age or younger;

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

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

3.~~(d)~~ Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, ~~unless specifically authorized under paragraph (c),~~ or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health

care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

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

(b) Are part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

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

Section 3. Section 408.9091, Florida Statutes, is created to read:

408.9091 Cover Florida Health Care Access Program.--

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

(2) LEGISLATIVE INTENT.--The Legislature finds that a significant number 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 intent of the Legislature 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) "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.

(c) "Cover Florida plan coverage" means health care services that are covered as benefits under a Cover Florida plan.

(d) "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.

(e) "Cover Florida Plus" 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.

(f) "Enrollee" means an individual who has been determined to be eligible for and is receiving health insurance coverage under a Cover Florida plan.

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

(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 on a guaranteed-issue basis 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 provide for cost containment through limits on the number of services, caps on benefit payments, and copayments for services.

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

5. In order to provide for consumer choice, Cover Florida 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 services including, but not limited to:

a. Preventive health services, including immunizations, annual health assessments, well-woman and well-care services, and preventive screenings such as mammograms, cervical cancer screenings, and noninvasive colorectal or prostate screenings.

b. Incentives for routine preventive care.

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

d. Office surgery, including anesthesia.

e. 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.; however, such plans may 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. All plans offer prescription drug benefit coverage, use a prescription drug manager, or offer a discount drug card.

9. Plan enrollment materials provide information in plain language on policy benefit coverage, benefit limits, cost-sharing requirements, and exclusions and a clear representation of what is not covered in the plan. Such enrollment materials must include a standard disclosure form adopted by rule by the Financial Services Commission, to be reviewed and executed by all consumers purchasing Cover Florida plan coverage.

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 the agency as provided under 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 Care Access Program.

(e) Public or private entities may design programs to encourage Floridians to participate in the Cover Florida Health Care 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 requirements:

(a) Are between 19 and 64 years of age, inclusive.

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

(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 which provides 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 pursuant to ss. 120.536(1) and 120.54 as needed to administer this section.

Section 4. Section 408.910, Florida Statutes, is created to

read:

408.910 Florida Health Choices Program.--

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

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

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

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

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

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

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

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

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

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

(c) "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, or an exclusive provider organization as defined in s. 627.6472.

(d) "Program" means the Florida Health Choices Program established by this section.

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

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

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

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

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

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

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

1. Employers that have 1 to 50 employees.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities having populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

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

1. Individual employees of enrolled employers.

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

3. State retirees.

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

5. Statutory rural hospitals.

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

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

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) Eligible vendors and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

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

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

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

5. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

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

A vendor described in subparagraphs 3.-6. may not sell products

that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation under the provisions of the Florida Insurance Code. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

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

1. Submission of required information.

2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

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

5. Selection of products and services.

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

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to make all risk-bearing products offered through the program guaranteed-issue policies,

subject to preexisting-condition exclusions established by the corporation.

3. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.

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

5. Arrangements for receiving payment for enrolled participants.

6. Participation in ongoing reporting processes established by the corporation.

7. Compliance with grievance procedures established by the corporation.

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

1. Completion of training requirements.

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

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

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.--

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

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types of health services and treatments.

6. Flexible spending accounts.

(b) Health insurance policies, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services and benefits to participating individuals for at least 1 full enrollment year.

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

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(6) PRICING.--Prices for the products sold through the program must be transparent to participants and established by

the vendors based on age, gender, and location of participants. The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period. The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

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

(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets

the requirements specified by the corporation pursuant to paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

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

(8) CONSUMER INFORMATION.--The corporation shall establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the

program.

(a) Prior to making a risk-bearing product available through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.

1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.

2. Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.

(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.

(9) RISK POOLING.--The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but are not limited to, a postenrollment risk adjustment of the premium payments to

the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.--

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

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.--There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112, chapter 119, chapter 286 and chapter 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

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

b. The Secretary of Management Services or a designee with

expertise in state employee benefits.

c. The Commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

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

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

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

(f) The board shall develop and adopt bylaws and other

corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

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

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

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

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

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

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

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

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

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

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

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2009.

(12) REPORT.--Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

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

Section 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. Section 624.1265, Florida Statutes, is created to read:

624.1265 Nonprofit religious organization exemption; authority; notice.--

(1) A nonprofit religious organization is not subject to the requirements of the Florida Insurance Code if the nonprofit religious organization qualifies under Title 26, s. 501 of the Internal Revenue Code of 1986, as amended; limits its participants to members of the same religion; acts as an organizational clearinghouse for information between participants

who have financial, physical, or medical needs and participants who have the ability to pay for the benefit of those participants who have financial, physical, or medical needs; provides for the financial or medical needs of a participant through payments directly from one participant to another participant; and suggests amounts that participants may voluntarily give with no assumption of risk or promise to pay among the participants or between the participants.

(2) This section does not prevent the organization described in subsection (1) from establishing qualifications of participation relating to the health of a prospective participant, does not prevent a participant from limiting the financial or medical needs that may be eligible for payment, and does not prevent the organization from canceling the membership of a participant when such participant indicates his or her unwillingness to participate by failing to make a payment to another participant for a period in excess of 60 days.

(3) The religious organization described in subsection (1) shall provide each prospective participant in the organizational clearinghouse written notice that the organization is not an insurance company, that membership is not offered through an insurance company, and that the organization is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Section 7. 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 Florida 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 8. Effective upon this act becoming a law and applicable to policies issued or renewed on or after October 1, 2008, paragraph (c) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.--

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

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

Section 9. Effective upon this act becoming a 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 under a group, blanket, or franchise health insurance policy 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 is not 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 provided in s. 627.6561(5).

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

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

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

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

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

(5)(a) Until April 1, 2009, the parent of a child who qualifies for coverage under subsection (2) but whose coverage as a dependent child under the parent's plan terminated under the terms of the plan before October 1, 2008, may make a written election to reinstate coverage, without proof of insurability, under that plan as a dependent child pursuant to this section.

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

election for coverage pursuant to paragraph (a).

(c) Notice regarding the reinstatement of coverage for a dependent child as provided under this subsection must be provided to a covered person in the certificate of coverage prepared for covered persons by the insurer or by the covered person's employer. Such notice may be given through the group policyholder.

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

Section 10. Effective upon this act becoming a law and applicable to contracts issued or renewed on or after October 1, 2008, subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) All health maintenance contracts providing coverage for a member of the subscriber's family must comply with the provisions of s. 627.6562.

Section 11. For the 2008-2009 fiscal year, the following is appropriated from the General Revenue Fund to the Agency for Health Care Administration to fund the Florida Health Choices Program:

(1) The sum of $325,000 in nonrecurring funds for the salaries and benefits of the chief executive office and staff of Florida Health Choices, Inc., for the 2008-2009 fiscal year.

(2) The sum of $825,000 in nonrecurring funds for costs related to the general administration, marketing, consulting, and other duties of the Florida Health Choices, Inc., for the 2008-2009 fiscal year.

(3) The sum of $350,000 in nonrecurring funds for the third-party administrator functions of Florida Health Choices Inc., during the 2008-2009 fiscal year.

Section 12. This act shall take effect upon becoming a law.