By Senator Bennett

21-03377A-08 20082704__

A bill to be entitled

An act relating to affordable health coverage; amending s. 408.909; redefining the term "health flex plan"; revising requirements for the Agency for Health Care Administration and the Office of Insurance Regulation in approving plans; revising eligibility requirements; extending the expiration date of the health flex plan program; amending s. 409.811, F.S.; redefining the term "premium assistance payment"; amending s. 627.602, F.S.; revising policy requirements pertaining to dependent children; providing a cross-reference; amending s. 627.653, F.S.; requiring participation of employees in group insurance policies or group health benefit plans issued or renewed after October 1, 2008; providing opt-out provisions for employers and employees related to such coverage; amending s. 627.6562, F.S.; expanding types of insurance policies providing for dependent coverage; extending the qualifying age for dependent coverage; revising eligibility requirements for dependents to receive continued coverage; providing clarifications and limitations on dependent coverage; providing mechanisms for reinstatement of dependent coverage; providing for payment of premium; requiring approval of premium payment requirements by the Office of Insurance Regulation; providing notice requirements for reinstated coverage of dependents; excluding certain types of health coverage policies; specifying the types of health coverage policies governed by the act; amending ss. 627.6699 and 641.31, F.S.; requiring participation of employees in health maintenance contracts or policies

issued or renewed after October 1, 2008; providing opt-out provisions for employers and employees related to such coverage; requiring compliance with s. 627.6562, F.S., for all heath maintenance contracts that provide coverage for family members; amending s. 641.402; redefining the terms "basic services," "prepaid health clinic," and "provider"; providing an effective date.

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

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

408.909 Health flex plans.--

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

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

(3) PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits or provider network requirements otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option

of a catastrophic plan or a catastrophic plan supplementing the health flex plan.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

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

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices;

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

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

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

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

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

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

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

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

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

(b) Are part of an employer group where at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employee group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under state 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 2. Subsection (22) of section 409.811, Florida Statutes, is amended to read:

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

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

Section 3. Paragraph (c) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.--

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

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

Section 4. Present subsection (4) of section 627.653, Florida Statutes, is redesignated as subsection (5), and a new subsection (4) is added to that section, to read:

627.653 Employee groups.--

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

Section 5. Section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.--

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

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

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

(c) Is not actually 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, Pub. L. No. 89-97 (42 U.S.C. s. 1395 et seq.).

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

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

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

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

(d) Prohibit an insurer or health maintenance organization from increasing the limiting age for dependent coverage to age 30 in policies or contracts issued or renewed before October 1, 2008.

(3) Until April 1, 2009, a dependent child who qualifies for coverage under subsection (1) but whose coverage as a dependent child under a covered person's plan terminated under the terms of the plan before October 1, 2008, may make a written election to reinstate coverage, without proof of insurability, under that plan as a dependent child pursuant to this section. All other dependent children who qualify for coverage under subsection (1) shall be automatically covered at least until the end of the calendar year in which the child reaches the age of

30, unless the covered person provides the group policyholder with written evidence that the dependent child is married, is not a state resident, or is covered under a separate comprehensive health insurance policy or a health benefit plan or is entitled to benefits under Title XVIII of the Social Security Act, Pub. L. No. 89-97 (42 U.S.C. s. 1935, et seq.).

(4) The covered person's plan may require the payment of a premium by the covered person or dependent child, as appropriate and 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 subsection (3).

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

(a) In the certificate of coverage prepared for covered persons by the insurer; or

(b) By the covered person's employer.

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

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

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

Section 6. Paragraph (h) of subsection (5) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

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

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. Unless the employer chooses otherwise, for all policies or health maintenance contracts issued or renewed after October 1, 2008, all eligible employees and their dependents shall be

enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage, which notice must include evidence of coverage under an existing group insurance policy or group health benefit plan, or other reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

4.~~3.~~ In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

5.~~4.~~ A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

6.~~5.~~ If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier

may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

7.~~6.~~ A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

8.~~7.~~ An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

Section 7. Subsections (41) and (42) are added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

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

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

Section 8. Subsections (1), (4), and (6) of section 641.402, Florida Statutes, are amended to read:

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

(1) "Basic services" includes any of the following: limited hospital inpatient services, which may include hospital inpatient physician services, up to a maximum coverage benefit of five days and a maximum dollar amount of coverage of $15,000 per calendar year; emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventive health care services.

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

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

Section 9. This act shall take effect upon becoming a law, except that sections 3, 4, 5, and 7 of this act shall take effect

October 1, 2008, and apply to all individual, group, blanket, franchise health insurance policies, and health maintenance contracts issued, renewed, or amended on or after that date.