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35 disapproved or withdrawn; authorizing the agency and the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 submit an annual
81 report to the Governor and Legislature; authorizing the
82 corporation to establish and enforce certain program
83 integrity measures; amending s. 409.811, F.S.; revising
84 the definition of the term "premium assistance payment";

85 creating s. 624.1265, F.S.; exempting certain nonprofit
86 religious organizations from requirements of the Florida
87 Insurance Code; preserving certain authority of such
88 organizations; requiring such organizations to provide
89 certain notice to prospective participants; providing
90 notice requirements; amending s. 627.602, F.S.; requiring
91 an insurance policy that includes coverage for dependent
92 children to comply with specified provisions relating to
93 dependent coverage; amending s. 627.653, F.S.; requiring
94 participation of employees in group insurance policies or
95 group health benefit plans issued or renewed after a
96 specified date; providing conditions for employers and
97 employees to opt out of such coverage; amending s.
98 627.6562, F.S.; specifying the types of insurance policies
99 that must provide for dependent coverage; extending the
100 qualifying age for dependent coverage from 25 to 30 years;
101 revising eligibility requirements for dependents to
102 receive continued coverage; providing clarifications and
103 limitations of dependent coverage; providing mechanisms
104 for reinstatement of dependent coverage; providing for
105 payment of premium; requiring approval of premium payment
106 requirements by the office; providing notice requirements
107 for reinstated coverage of dependents; providing
108 applicability; amending s. 627.6699, F.S.; requiring
109 participation of employees in health maintenance contracts
110 or policies issued or renewed after a specified date;
111 providing conditions for employers and employees to opt
112 out of such coverage; amending s. 641.31, F.S.; requiring

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113 participation of employees in policies or health
114 maintenance contracts issued or renewed after a specified
115 date; providing conditions for employers and employees to
116 opt out of such coverage; requiring all heath maintenance
117 contracts that provide coverage for family members to
118 comply with certain statutory provisions; amending s.
119 641.402, F.S.; revising the definition of the term "basic
120 services" to include certain hospital inpatient services;
121 revising the definitions of the terms "prepaid health
122 clinic" and "provider"; providing an effective date.
123
124 Be It Enacted by the Legislature of the State of Florida:
125
126 Section 1. Paragraph (d) of subsection (2) of section
127 112.363, Florida Statutes, is amended to read:
128 112.363 Retiree health insurance subsidy.--
129 (2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.--
130 (d) Payment of the retiree health insurance subsidy shall
131 be made only after coverage for health insurance for the retiree
132 or beneficiary has been certified in writing to the Department
133 of Management Services. Participation in a former employer's
134 group health insurance program is not a requirement for
135 eligibility under this section. Coverage issued pursuant to s.
136 408.9091 is considered health insurance for the purposes of this
137 section.
138 Section 2. Paragraph (e) of subsection (2) and subsections
139 (3), (5), and (10) of section 408.909, Florida Statutes, are
140 amended to read:

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

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169 office shall disapprove or shall withdraw approval of plans
170 that:
171 1. Contain any ambiguous, inconsistent, or misleading
172 provisions or any exceptions or conditions that deceptively
173 affect or limit the benefits purported to be assumed in the
174 general coverage provided by the health flex plan;
175 2. Provide benefits that are unreasonable in relation to
176 the premium charged or contain provisions that are unfair or
177 inequitable or contrary to the public policy of this state, that
178 encourage misrepresentation, or that result in unfair
179 discrimination in sales practices;
180 3. Cannot demonstrate that the health flex plan is
181 financially sound and that the applicant is able to underwrite
182 or finance the health care coverage provided; or
183 4. Cannot demonstrate that the applicant and its
184 management are in compliance with the standards required under
185 s. 624.404(3).
186 (c) The agency and the Financial Services Commission may
187 adopt rules as needed to administer this section.
188 (5) ELIGIBILITY.--Eligibility to enroll in an approved
189 health flex plan is limited to residents of this state who:
190 (a)<u>1.</u> Are 64 years of age or younger;
191 <u>2.</u>~~(b)~~ Have a family income equal to or less than 200
192 percent of the federal poverty level;
193 ~~(c) Are eligible under a federally approved Medicaid~~
194 ~~demonstration waiver and reside in Palm Beach County or Miami-~~
195 ~~Dade County;~~

196 3. ~~(d)~~ Are not covered by a private insurance policy and
197 are not eligible for coverage through a public health insurance
198 program, such as Medicare or Medicaid, ~~unless specifically~~
199 ~~authorized under paragraph (c),~~ or another public health care
200 program, such as Kidcare, and have not been covered at any time
201 during the past 6 months, except that:
202 a. A person who was covered under an individual health
203 maintenance contract issued by a health maintenance organization
204 licensed under part I of chapter 641 that also was an approved
205 health flex plan on October 1, 2008, may apply for coverage in
206 the same health maintenance organization's health flex plan
207 without a lapse in coverage if all other eligibility
208 requirements are met; or
209 b. A person who was covered under Medicaid or Kidcare and
210 lost eligibility for the Medicaid or Kidcare subsidy due to
211 income restrictions within 90 days prior to applying for health
212 care coverage through an approved health flex plan may apply for
213 coverage in a health flex plan without a lapse in coverage if
214 all other eligibility requirements are met; and
215 4. ~~(e)~~ Have applied for health care coverage as an
216 individual through an approved health flex plan and have agreed
217 to make any payments required for participation, including
218 periodic payments or payments due at the time health care
219 services are provided; or
220 (b) Are part of an employer group at least 75 percent of
221 the employees of which have a family income equal to or less
222 than 300 percent of the federal poverty level and which employee
223 group is not covered by a private health insurance policy and

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224 has not been covered at any time during the past 6 months. If
225 the health flex plan entity is a health insurer, health plan, or
226 health maintenance organization licensed under Florida law, only
227 50 percent of the employees must meet the income requirements
228 for the purpose of this paragraph.
229 ~~(10) EXPIRATION.--This section expires July 1, 2008.~~
230 Section 3. Section 408.9091, Florida Statutes, is created
231 to read:
232 408.9091 Cover Florida Health Care Access Program.--
233 (1) SHORT TITLE.--This section may be cited as the "Cover
234 Florida Health Care Access Program Act."
235 (2) LEGISLATIVE INTENT.--The Legislature finds that a
236 significant number of state residents are unable to obtain
237 affordable health insurance coverage. The Legislature also finds
238 that existing health flex plan coverage has had limited
239 participation due in part to narrow eligibility restrictions as
240 well as minimal benefit options for catastrophic and emergency
241 care coverage. Therefore, it is the intent of the Legislature to
242 expand the availability of health care options for uninsured
243 residents by developing an affordable health care product that
244 emphasizes coverage for basic and preventive health care
245 services; provides inpatient hospital, urgent, and emergency
246 care services; and is offered statewide by approved health
247 insurers, health maintenance organizations, health-care-
248 provider-sponsored organizations, or health care districts.
249 (3) DEFINITIONS.--As used in this section, the term:
250 (a) "Agency" means the Agency for Health Care
251 Administration.

252 (b) "Cover Florida plan" means a consumer choice benefit
253 plan approved under this section that guarantees payment or
254 coverage for specified benefits provided to an enrollee.
255 (c) "Cover Florida plan coverage" means health care
256 services that are covered as benefits under a Cover Florida
257 plan.
258 (d) "Cover Florida plan entity" means a health insurer,
259 health maintenance organization, health-care-provider-sponsored
260 organization, or health care district that develops and
261 implements a Cover Florida plan and is responsible for
262 administering the plan and paying all claims for Cover Florida
263 plan coverage by enrollees.
264 (e) "Cover Florida Plus" means a supplemental insurance
265 product, such as for additional catastrophic coverage or dental,
266 vision, or cancer coverage, approved under this section and
267 offered to all enrollees.
268 (f) "Enrollee" means an individual who has been determined
269 to be eligible for and is receiving health insurance coverage
270 under a Cover Florida plan.
271 (g) "Office" means the Office of Insurance Regulation of
272 the Financial Services Commission.
273 (4) PROGRAM.--The agency and the office shall jointly
274 establish and administer the Cover Florida Health Care Access
275 Program.
276 (a) General Cover Florida plan components must require
277 that:

278 1. Plans are offered on a guaranteed-issue basis to
279 enrollees, subject to exclusions for preexisting conditions
280 approved by the office and the agency.
281 2. Plans are portable such that the enrollee remains
282 covered regardless of employment status or the cost-sharing of
283 premiums.
284 3. Plans provide for cost containment through limits on
285 the number of services, caps on benefit payments, and copayments
286 for services.
287 4. A Cover Florida plan entity makes all benefit plan and
288 marketing materials available in English and Spanish.
289 5. In order to provide for consumer choice, Cover Florida
290 plan entities develop two alternative benefit option plans
291 having different cost and benefit levels, including at least one
292 plan that provides catastrophic coverage.
293 6. Plans without catastrophic coverage provide coverage
294 options for services including, but not limited to:
295 a. Preventive health services, including immunizations,
296 annual health assessments, well-woman and well-care services,
297 and preventive screenings such as mammograms, cervical cancer
298 screenings, and noninvasive colorectal or prostate screenings.
299 b. Incentives for routine preventive care.
300 c. Office visits for the diagnosis and treatment of
301 illness or injury.
302 d. Office surgery, including anesthesia.
303 e. Behavioral health services.
304 f. Durable medical equipment and prosthetics.
305 g. Diabetic supplies.

306 7. Plans providing catastrophic coverage, at a minimum,
307 provide coverage options for all of the services listed under
308 subparagraph 6.; however, such plans may include, but are not
309 limited to, coverage options for:
310 a. Inpatient hospital stays.
311 b. Hospital emergency care services.
312 c. Urgent care services.
313 d. Outpatient facility services, outpatient surgery, and
314 outpatient diagnostic services.
315 8. All plans offer prescription drug benefit coverage or
316 use a prescription drug manager such as the Florida Discount
317 Drug Card Program.
318 9. Plan enrollment materials provide information in plain
319 language on policy benefit coverage, benefit limits, cost-
320 sharing requirements, and exclusions and a clear representation
321 of what is not covered in the plan. The Cover Florida Health
322 Care Access Program shall require the following disclosure to be
323 reviewed and executed by all consumers purchasing program
324 options or insurance coverage through the program: "In
325 connection with the Cover Florida Health Care Access Program
326 authorized by s. 408.9091, Florida Statutes, agents and entities
327 offering products and services under the program shall inform
328 the named insured, applicant, or subscriber, on a form approved
329 by the Office of Insurance Regulation of the Financial Services
330 Commission, that the program is not an insurance program or, if
331 it is an insurance program, that benefits under the coverage are
332 limited under s. 408.9091, Florida Statutes, and that such
333 coverage is an alternative to coverage without such limitations.

334 If the form is signed by a named insured, applicant, or
335 subscriber, it shall be presumed that there was an informed,
336 knowing acceptance of such limitations."
337 10. Plans offered through a qualified employer meet the
338 requirements of s. 125 of the Internal Revenue Code.
339 (b) Guidelines shall be developed to ensure that Cover
340 Florida plans meet minimum standards for quality of care and
341 access to care. The agency shall ensure that the Cover Florida
342 plans follow standardized grievance procedures.
343 (c) Changes in Cover Florida plan benefits, premiums, and
344 policy forms are subject to regulatory oversight by the office
345 and the agency as provided under rules adopted by the Financial
346 Services Commission and the agency.
347 (d) The agency, the office, and the Executive Office of
348 the Governor shall develop a public awareness program to be
349 implemented throughout the state for the promotion of the Cover
350 Florida Health Care Access Program.
351 (e) Public or private entities may design programs to
352 encourage Floridians to participate in the Cover Florida Health
353 Care Access Program or to encourage employers to cosponsor some
354 share of Cover Florida plan premiums for employees.
355 (5) PLAN PROPOSALS.--The agency and the office shall
356 announce, no later than July 1, 2008, an invitation to negotiate
357 for Cover Florida plan entities to design a Cover Florida plan
358 proposal in which benefits and premiums are specified.
359 (a) The invitation to negotiate shall include guidelines
360 for the review of Cover Florida plan applications, policy forms,
361 and all associated forms and provide regulatory oversight of

362 Cover Florida plan advertisement and marketing procedures. A
363 plan shall be disapproved or withdrawn if the plan:
364 1. Contains any ambiguous, inconsistent, or misleading
365 provisions or any exceptions or conditions that deceptively
366 affect or limit the benefits purported to be assumed in the
367 general coverage provided by the plan;
368 2. Provides benefits that are unreasonable in relation to
369 the premium charged or contains provisions that are unfair or
370 inequitable, that are contrary to the public policy of this
371 state, that encourage misrepresentation, or that result in
372 unfair discrimination in sales practices;
373 3. Cannot demonstrate that the plan is financially sound
374 and that the applicant is able to underwrite or finance the
375 health care coverage provided;
376 4. Cannot demonstrate that the applicant and its
377 management are in compliance with the standards required under
378 s. 624.404(3); or
379 5. Does not guarantee that enrollees may participate in
380 the Cover Florida plan entity's comprehensive network of
381 providers, as determined by the office, the agency, and the
382 contract.
383 (b) The agency and the office may announce an invitation
384 to negotiate for companies that offer supplemental insurance or
385 discount medical plans that are licensed under part II of
386 chapter 636 to design Cover Florida Plus products.
387 (c) The agency and office shall approve at least one Cover
388 Florida plan entity having an existing statewide network of

389 providers and may approve at least one regional network plan in
390 each existing Medicaid area.
391 (6) LICENSE NOT REQUIRED.--
392 (a) The licensing requirements of the Florida Insurance
393 Code and chapter 641 relating to health maintenance
394 organizations do not apply to a Cover Florida plan approved
395 under this section unless expressly made applicable. However,
396 for the purpose of prohibiting unfair trade practices, Cover
397 Florida plans are considered to be insurance subject to the
398 applicable provisions of part IX of chapter 626 except as
399 otherwise provided in this section.
400 (b) Cover Florida plans are not covered by the Florida
401 Life and Health Insurance Guaranty Association under part III of
402 chapter 631 or by the Health Maintenance Organization Consumer
403 Assistance Plan under part IV of chapter 631.
404 (7) ELIGIBILITY.--Eligibility to enroll in a Cover Florida
405 plan is limited to residents of this state who meet all of the
406 following requirements:
407 (a) Are between 19 and 64 years of age, inclusive.
408 (b) Are not covered by a private insurance policy and are
409 not eligible for coverage through a public health insurance
410 program, such as Medicare, Medicaid, or Kidcare, unless
411 eligibility for coverage lapses due to no longer meeting income
412 or categorical requirements.
413 (c) Have not been covered by any health insurance program
414 at any time during the past 6 months, unless coverage under a
415 health insurance program was terminated within the previous 6
416 months due to:

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417 1. Loss of a job that provided an employer-sponsored
418 health benefit plan;
419 2. Exhaustion of coverage that was continued under COBRA
420 or continuation-of-coverage requirements under s. 627.6692;
421 3. Reaching the limiting age under the policy; or
422 4. Death of, or divorce from, a spouse who was provided an
423 employer-sponsored health benefit plan.
424 (d) Have applied for health care coverage through a Cover
425 Florida plan and have agreed to make any payments required for
426 participation, including periodic payments or payments due at
427 the time health care services are provided.
428 (8) RECORDS.--Each Cover Florida plan must maintain
429 enrollment data and provide network data and reasonable records
430 to enable the office and the agency to monitor plans and to
431 determine the financial viability of the Cover Florida plan, as
432 necessary.
433 (9) NONENTITLEMENT.--Coverage under a Cover Florida plan
434 is not an entitlement, and a cause of action does not arise
435 against the state, a local government entity, any other
436 political subdivision of the state, or the agency or the office
437 for failure to make coverage available to eligible persons under
438 this section.
439 (10) PROGRAM EVALUATION.--The agency and the office shall:
440 (a) Evaluate the Cover Florida Health Care Access Program
441 and its effect on the entities that seek approval as Cover
442 Florida plans, on the number of enrollees, and on the scope of
443 the health care coverage offered under a Cover Florida plan.

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

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470 (b) Preserve the benefits of employment-sponsored
471 insurance while easing the administrative burden for employers
472 who offer these benefits.
473 (c) Enable individual choice in both the manner and amount
474 of health care purchased.
475 (d) Provide for the purchase of individual, portable
476 health care coverage.
477 (e) Disseminate information to consumers on the price and
478 quality of health services.
479 (f) Sponsor a competitive market that stimulates product
480 innovation, quality improvement, and efficiency in the
481 production and delivery of health services.
482 (2) DEFINITIONS.--As used in this section:
483 (a) "Corporation" means the Florida Health Choices, Inc.,
484 established under this section.
485 (b) "Health insurance agent" means an agent licensed under
486 part IV of chapter 626.
487 (c) "Insurer" means an individual health insurance policy
488 subject to this chapter, an insurer issuing a group health
489 insurance policy or certificate pursuant to s. 627.651, a plan
490 of self-insurance providing health coverage benefits to
491 residents of this state pursuant to s. 627.651, an insurer
492 delivering a group health policy issued or delivered outside
493 this state under which a resident of this state is provided
494 coverage pursuant to s. 627.6515, a preferred provider
495 organization as defined in s. 627.6471, or an exclusive provider
496 organization as defined in s. 627.6472.

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

525 3. Account information to assist individual participants
526 to manage available resources.
527 4. Services that promote healthy behaviors.
528 (d) Recruitment of vendors, including insurers, health
529 maintenance organizations, prepaid clinic service providers,
530 provider service networks, and other providers.
531 (e) Certification of vendors to ensure capability,
532 reliability, and validity of offerings.
533 (f) Collection of data, monitoring, assessment, and
534 reporting of vendor performance.
535 (g) Information services for individuals and employers.
536 (h) Program evaluation.
537 (4) ELIGIBILITY AND PARTICIPATION.--Participation in the
538 program is voluntary and shall be available to employers,
539 individuals, vendors, and health insurance agents as specified
540 in this subsection.
541 (a) Employers eligible to enroll in the program include:
542 1. Employers with 1 to 50 employees.
543 2. Fiscally constrained counties described in s. 218.67.
544 3. Municipalities with populations of fewer than 50,000
545 residents.
546 4. School districts in fiscally constrained counties.
547 (b) Individuals eligible to participate in the program
548 include:
549 1. Individual employees of enrolled employers.
550 2. State employees not eligible for state employee health
551 benefits.
552 3. State retirees.

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

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

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607
608 Otherwise eligible vendors may be excluded from participating in
609 the program for deceptive or predatory practices, financial
610 insolvency, or failure to comply with the terms of the
611 participation agreement or other standards set by the
612 corporation.
613 (e) Eligible individuals may voluntarily continue
614 participation in the program regardless of subsequent changes in
615 job status or Medicaid eligibility. Individuals who join the
616 program may participate by complying with the procedures
617 established by the corporation. These procedures shall include,
618 but are not limited to:
619 1. Submission of required information.
620 2. Authorization for payroll deduction.
621 3. Compliance with federal tax requirements.
622 4. Arrangements for payment in the event of job changes.
623 5. Selection of products and services.
624 (f) Vendors who choose to participate in the program may
625 enroll by complying with the procedures established by the
626 corporation. These procedures shall include, but are not limited
627 to:
628 1. Submission of required information, including a
629 complete description of the coverage, services, provider
630 network, payment restrictions, and other requirements of each
631 product offered through the program.
632 2. Execution of an agreement to make all products offered
633 through the program available to all individual participants.

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

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

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

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

746 limits do not apply to initiation of flexible spending plans
747 when those plans are not associated with specific high-
748 deductible insurance policies or to the use of spending accounts
749 for any products offering individual participants specific
750 amounts and types of health services and treatments at a
751 contracted price.
752 (8) RISK POOLING.--The program shall utilize methods for
753 pooling the risk of individual participants and preventing
754 selection bias. These methods shall include, but not be limited
755 to, a postenrollment risk adjustment of the premium payments to
756 the vendors. The corporation shall establish a methodology for
757 assessing the risk of enrolled individual participants based on
758 data reported by the vendors about their enrollees. Monthly
759 distributions of payments to the vendors shall be adjusted based
760 on the assessed relative risk profile of the enrollees in each
761 risk-bearing product for the most recent period for which data
762 is available.
763 (9) EXEMPTIONS.--
764 (a) Policies sold as part of the program are not subject
765 to the licensing requirements of the Florida Insurance Code,
766 chapter 641, or the mandated offerings or coverages established
767 in part VI of chapter 627 and chapter 641.
768 (b) The corporation is authorized to act as an
769 administrator as defined in s. 626.88. However, the corporation
770 is not subject to the licensing requirements of part VII of
771 chapter 626.
772 (10) LIQUIDATION OR DISSOLUTION.--The Department of
773 Financial Services shall supervise any liquidation or

774 dissolution of the corporation and shall have, with respect to
775 such liquidation or dissolution, all power granted to it
776 pursuant to the Florida Insurance Code.
777 (11) CORPORATION.--There is created the Florida Health
778 Choices, Inc., which shall be registered, incorporated,
779 organized, and operated in compliance with chapter 617. The
780 purpose of the corporation is to administer the program created
781 in this section and to conduct such other business as may
782 further the administration of the program.
783 (a) The corporation shall be governed by a board of
784 directors consisting of 15 individuals appointed in the
785 following manner:
786 1. Five members appointed by and serving at the pleasure
787 of the Governor, consisting of:
788 a. The Secretary of Health Care Administration or a
789 designee with expertise in health care services.
790 b. The Secretary of Management Services or a designee with
791 expertise in state employee benefits.
792 c. Three representatives of eligible public employers.
793 2. Five members appointed by and serving at the pleasure
794 of the President of the Senate, consisting of representatives of
795 employers, insurers, health care providers, health insurance
796 agents, and individual participants.
797 3. Five members appointed by and serving at the pleasure
798 of the Speaker of the House of Representatives, consisting of
799 representatives of employers, insurers, health care providers,
800 health insurance agents, and individual participants.

801 (b) Members shall be appointed for terms of up to 3 years.
802 Any member is eligible for reappointment. A vacancy on the board
803 shall be filled for the unexpired portion of the term in the
804 same manner as the original appointment.
805 (c) The board shall select a chief executive officer for
806 the corporation who shall be responsible for the selection of
807 such other staff as may be authorized by the corporation's
808 operating budget as adopted by the board.
809 (d) Board members are entitled to receive, from funds of
810 the corporation, reimbursement for per diem and travel expenses
811 as provided by s. 112.061. No other compensation is authorized.
812 (e) There shall be no liability on the part of, and no
813 cause of action shall arise against, any member of the board or
814 its employees or agents for any action taken by them in the
815 performance of their powers and duties under this section.
816 (f) The board shall develop and adopt bylaws and other
817 corporate procedures as necessary for the operation of the
818 corporation and carrying out the purposes of this section. The
819 bylaws shall specify procedures for selection of officers and
820 qualifications for reappointment, provided that no board member
821 shall serve more than 8 consecutive years. The bylaws shall also
822 require an annual membership meeting that provides an
823 opportunity for input and interaction with individual
824 participants in the program.
825 (g) The corporation may exercise all powers granted to it
826 under chapter 617 necessary to carry out the purposes of this
827 section, including, but not limited to, the power to receive and
828 accept grants, loans, or advances of funds from any public or

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

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855 9. Establish policies and procedures regarding
856 participation in the program for individuals, vendors, health
857 insurance agents, and employers.
858 10. Beginning in fiscal year 2009-2010, submit by February
859 1 an annual report to the Governor, the President of the Senate,
860 and the Speaker of the House of Representatives documenting the
861 corporation's activities in compliance with the duties
862 delineated in this section.
863 (i) To ensure program integrity and to safeguard the
864 financial transactions made under the auspices of the program,
865 the corporation is authorized to establish qualifying criteria
866 and certification procedures for vendors, require performance
867 bonds or other guarantees of ability to complete contractual
868 obligations, monitor the performance of vendors, and enforce the
869 agreements of the program through financial penalty or
870 disqualification from the program.
871 Section 5. Subsection (22) of section 409.811, Florida
872 Statutes, is amended to read:
873 409.811 Definitions relating to Florida Kidcare Act.--As
874 used in ss. 409.810-409.820, the term:
875 (22) "Premium assistance payment" means the monthly
876 consideration paid by the agency per enrollee in the Florida
877 Kidcare program towards health insurance premiums and may
878 include the direct payment of the premium for a qualifying child
879 to be covered as a dependent under an employer-sponsored group
880 family plan when such payment does not exceed the payment
881 required for an enrollee in the Florida Kidcare program.

882 Section 6. Section 624.1265, Florida Statutes, is created
883 to read:
884 624.1265 Nonprofit religious organization exemption;
885 authority; notice.--
886 (1) Any nonprofit religious organization that qualifies
887 under Title 26, s. 501 of the Internal Revenue Code of 1986, as
888 amended; that limits its participants to members of the same
889 religion; that acts as an organizational clearinghouse for
890 information between participants who have financial, physical,
891 or medical needs and participants with the ability to pay for
892 the benefit of those participants with financial, physical, or
893 medical needs; that provides for the financial or medical needs
894 of a participant through payments directly from one participant
895 to another; and that suggests amounts that participants may
896 voluntarily give with no assumption of risk or promise to pay
897 either among the participants or between the participants and
898 the organization are not subject to any requirements of the
899 Florida Insurance Code.
900 (2) Nothing in this section prevents the organization
901 described in subsection (1) from establishing qualifications of
902 participation relating to the health of a prospective
903 participant, prevents a participant from limiting the financial
904 or medical needs that may be eligible for payment, or prevents
905 the organization from canceling the membership of a participant
906 when such participant indicates his or her unwillingness to
907 participate by failing to make a payment to another participant
908 for a period in excess of 60 days.
909 (3) The organization described in subsection (1) shall

910 provide each prospective participant in the organizational
911 clearinghouse written notice that the organization is not an
912 insurance company, that membership is not offered through an
913 insurance company, and that the organization is not subject to
914 the regulatory requirements or consumer protections of the
915 Florida Insurance Code.
916 Section 7. Paragraph (c) of subsection (1) of section
917 627.602, Florida Statutes, is amended to read:
918 627.602 Scope, format of policy.--
919 (1) Each health insurance policy delivered or issued for
920 delivery to any person in this state must comply with all
921 applicable provisions of this code and all of the following
922 requirements:
923 (c) The policy may purport to insure only one person,
924 except that upon the application of an adult member of a family,
925 who is deemed to be the policyholder, a policy may insure,
926 either originally or by subsequent amendment, any eligible
927 members of that family, including husband, wife, any children or
928 any person dependent upon the policyholder. If an insurer offers
929 coverage that insures dependent children of the policyholder,
930 the policy must comply with s. 627.6562.
931 Section 8. Subsection (4) of section 627.653, Florida
932 Statutes, is renumbered as subsection (5), and a new subsection
933 (4) is added to that section to read:
934 627.653 Employee groups.--
935 (4) Unless the employer chooses otherwise, for all
936 policies issued or renewed after October 1, 2008, all eligible
937 employees and their dependents shall be enrolled for coverage at

938 <u>the time of issuance or during the next open or special</u>
939 <u>enrollment period, unless the employee provides written notice</u>
940 <u>to the employer declining coverage, which notice shall include</u>
941 <u>evidence of coverage under an existing group insurance policy or</u>
942 <u>group health benefit plan or other reasons for declining</u>
943 <u>coverage. Such notice shall be retained by the employer as part</u>
944 <u>of the employee's employment or insurance file. An employer may</u>
945 <u>require its employees to participate in its group health plan as</u>
946 <u>a condition of employment. This subsection shall apply to all</u>
947 <u>individual, group, blanket, and franchise health insurance</u>
948 <u>policies and health maintenance contracts issued, renewed, or</u>
949 <u>amended after October 1, 2008.</u>
950 Section 9. Section 627.6562, Florida Statutes, is amended
951 to read:
952 627.6562 Dependent coverage.--
953 (1) If an insurer offers<u>, under a group, blanket, or</u>
954 <u>franchise health insurance policy,</u> coverage that insures
955 dependent children of the policyholder or certificateholder, the
956 policy must insure a dependent child of the policyholder or
957 certificateholder at least until the end of the calendar year in
958 which the child reaches the age of <u>30</u> ~~25,~~ if the child ~~meets all~~
959 ~~of the following~~:
960 (a) <u>Is unmarried and is a dependent as defined in the</u>
961 <u>Federal Tax Code</u> ~~The child is dependent upon the policyholder or~~
962 ~~certificateholder for support~~.
963 (b) <u>Is a resident of this state</u> ~~The child is living in the~~
964 ~~household of the policyholder or certificateholder, or the child~~
965 ~~is a full-time or part-time student~~.

966 (c) Is not provided coverage as a named subscriber,
967 insured, enrollee, or covered person under any other group,
968 blanket, or franchise health insurance policy or individual
969 health benefit plan or entitled to benefits under Title XVIII of
970 the Social Security Act, Pub. L. No. 89-97, 42 U.S.C. ss. 1395
971 et seq.
972 (d) Is not eligible for coverage as an employee under an
973 employer sponsored health plan.
974 (2) ~~Nothing in~~ This section does not:
975 (a) Affect or preempt ~~affects or preempts~~ an insurer's
976 right to medically underwrite or charge the appropriate premium.
977 (b) Require coverage for services provided to a dependent
978 before October 1, 2008.
979 (c) Require an employer to pay all or part of the cost of
980 coverage provided for a dependent under this section.
981 (d) Prohibit an insurer or health maintenance organization
982 from increasing the limiting age for dependent coverage to age
983 30 in policies or contracts issued or renewed prior to the
984 effective date of this act.
985 (3) Until April 1, 2009, a dependent child who qualifies
986 for coverage under subsection (1) but whose coverage as a
987 dependent child under a covered person's plan terminated under
988 the terms of the plan before October 1, 2008, may make a written
989 election to reinstate coverage, without proof of insurability,
990 under that plan as a dependent child pursuant to this section.
991 All other dependent children who qualify for coverage under
992 subsection (1) shall be automatically covered at least until the
993 end of the calendar year in which the child reaches the age of

994 30, unless the covered person provides the group policyholder
995 with written evidence the dependent child is married, is not a
996 resident of the state, is covered under a separate comprehensive
997 health insurance policy or a health benefit plan, is entitled to
998 benefits under Title XVIII of the Social Security Act, Pub. L.
999 No. 89-97, 42 U.S.C. ss. 1935 et seq., or is eligible for
1000 coverage as an employee under an employer-sponsored health plan.
1001 (4) The covered person's plan may require the payment of a
1002 premium by the covered person or dependent child, as
1003 appropriate, subject to the approval of the Office of Insurance
1004 Regulation, for any period of coverage relating to a dependent's
1005 written election for coverage pursuant to subsection (3).
1006 (5) Notice regarding the reinstatement of coverage for a
1007 dependent child as provided under this section must be provided
1008 to a covered person in the certificate of coverage prepared for
1009 covered persons by the insurer or by the covered person's
1010 employer. The notice shall be given as soon as practicable after
1011 July 1, 2008, and such notice may be given through the group
1012 policyholder.
1013 (6) This section does not apply to accident only,
1014 specified disease, disability income, Medicare supplement, or
1015 long-term care insurance policies.
1016 (7) This section applies to all group, blanket, and
1017 franchise health insurance policies covering residents of this
1018 state, including, but not limited to, policies in which the
1019 carrier has reserved the right to change the premium. This
1020 section applies to all individual, group, blanket, and franchise

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1021 health insurance policies and health maintenance contracts
1022 issued, renewed, or amended after October 1, 2008.
1023 Section 10. Paragraph (h) of subsection (5) of section
1024 627.6699, Florida Statutes, is amended to read:
1025 627.6699 Employee Health Care Access Act.--
1026 (5) AVAILABILITY OF COVERAGE.--
1027 (h) All health benefit plans issued under this section
1028 must comply with the following conditions:
1029 1. For employers who have fewer than two employees, a late
1030 enrollee may be excluded from coverage for no longer than 24
1031 months if he or she was not covered by creditable coverage
1032 continually to a date not more than 63 days before the effective
1033 date of his or her new coverage.
1034 2. Any requirement used by a small employer carrier in
1035 determining whether to provide coverage to a small employer
1036 group, including requirements for minimum participation of
1037 eligible employees and minimum employer contributions, must be
1038 applied uniformly among all small employer groups having the
1039 same number of eligible employees applying for coverage or
1040 receiving coverage from the small employer carrier, except that
1041 a small employer carrier that participates in, administers, or
1042 issues health benefits pursuant to s. 381.0406 which do not
1043 include a preexisting condition exclusion may require as a
1044 condition of offering such benefits that the employer has had no
1045 health insurance coverage for its employees for a period of at
1046 least 6 months. A small employer carrier may vary application of
1047 minimum participation requirements and minimum employer

1048 contribution requirements only by the size of the small employer
1049 group.
1050 3. Unless the employer chooses otherwise, for all policies
1051 or health maintenance contracts issued or renewed after October
1052 1, 2008, all eligible employees and their dependents shall be
1053 enrolled for coverage at the time of issuance or during the next
1054 open or special enrollment period, unless the employee provides
1055 written notice to the employer declining coverage, which notice
1056 shall include evidence of coverage under an existing group
1057 insurance policy or group health benefit plan or other reasons
1058 for declining coverage. Such notice shall be retained by the
1059 employer as part of the employee's employment or insurance file.
1060 An employer may require its employees to participate in its
1061 group health plan as a condition of employment.
1062 4.~~3.~~ In applying minimum participation requirements with
1063 respect to a small employer, a small employer carrier shall not
1064 consider as an eligible employee employees or dependents who
1065 have qualifying existing coverage in an employer-based group
1066 insurance plan or an ERISA qualified self-insurance plan in
1067 determining whether the applicable percentage of participation
1068 is met. However, a small employer carrier may count eligible
1069 employees and dependents who have coverage under another health
1070 plan that is sponsored by that employer.
1071 5.~~4.~~ A small employer carrier shall not increase any
1072 requirement for minimum employee participation or any
1073 requirement for minimum employer contribution applicable to a
1074 small employer at any time after the small employer has been
1075 accepted for coverage, unless the employer size has changed, in

1076 which case the small employer carrier may apply the requirements
1077 that are applicable to the new group size.
1078 6.~~5.~~ If a small employer carrier offers coverage to a
1079 small employer, it must offer coverage to all the small
1080 employer's eligible employees and their dependents. A small
1081 employer carrier may not offer coverage limited to certain
1082 persons in a group or to part of a group, except with respect to
1083 late enrollees.
1084 7.~~6.~~ A small employer carrier may not modify any health
1085 benefit plan issued to a small employer with respect to a small
1086 employer or any eligible employee or dependent through riders,
1087 endorsements, or otherwise to restrict or exclude coverage for
1088 certain diseases or medical conditions otherwise covered by the
1089 health benefit plan.
1090 8.~~7.~~ An initial enrollment period of at least 30 days must
1091 be provided. An annual 30-day open enrollment period must be
1092 offered to each small employer's eligible employees and their
1093 dependents. A small employer carrier must provide special
1094 enrollment periods as required by s. 627.65615.
1095 Section 11. Subsections (41) and (42) are added to section
1096 641.31, Florida Statutes, to read:
1097 641.31 Health maintenance contracts.--
1098 (41) Unless the employer chooses otherwise, for all
1099 policies or health maintenance contracts issued or renewed after
1100 October 1, 2008, all eligible employees and their dependents
1101 shall be enrolled for coverage at the time of issuance or during
1102 the next open or special enrollment period, unless the employee
1103 provides written notice to the employer declining coverage,

1104 which notice shall include evidence of coverage under an
1105 existing group insurance policy or group health benefit plan or
1106 other reasons for declining coverage. Such notice shall be
1107 retained by the employer as part of the employee's employment or
1108 insurance file. An employer may require its employees to
1109 participate in its group health plan as a condition of
1110 employment. This subsection shall apply to all individual,
1111 group, blanket, and franchise health insurance policies and
1112 health maintenance contracts issued, renewed, or amended after
1113 October 1, 2008.
1114 (42) All health maintenance contracts that provide
1115 coverage for a member of the family of the subscriber shall
1116 comply with s. 627.6562.
1117 Section 12. Subsections (1), (4), and (6) of section
1118 641.402, Florida Statutes, are amended to read:
1119 641.402 Definitions.--As used in this part, the term:
1120 (1) "Basic services" includes any of the following:
1121 limited hospital inpatient services, which may include hospital
1122 inpatient physician services, up to a maximum of coverage
1123 benefit of 5 days and a maximum dollar amount of coverage of
1124 $15,000 per calendar year; emergency care;, physician care other
1125 than hospital inpatient physician services;, ambulatory
1126 diagnostic treatment;, and preventive health care services.
1127 (4) "Prepaid health clinic" means any organization
1128 authorized under this part which provides, either directly or
1129 through arrangements with other persons, basic services to
1130 persons enrolled with such organization, on a prepaid per capita
1131 or prepaid aggregate fixed-sum basis, including those basic

1132 services described in this part which subscribers might
1133 reasonably require to maintain good health. ~~However, no clinic~~
1134 ~~that provides or contracts for, either directly or indirectly,~~
1135 ~~inpatient hospital services, hospital inpatient physician~~
1136 ~~services, or indemnity against the cost of such services shall~~
1137 ~~be a prepaid health clinic.~~
1138 (6) "Provider" means any physician or person ~~other than a~~
1139 ~~hospital~~ that furnishes health care services under this part and
1140 is licensed or authorized to practice in this state.
1141 Section 13. This act shall take effect upon becoming a
1142 law.