

Select Year:

The 2008 Florida Statutes

Title XXIX
PUBLIC HEALTH

Chapter 408
HEALTH CARE ADMINISTRATION

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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.

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(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.

History.--s. 3, ch. 2008-32.

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Title XXXVII
INSURANCEChapter 627
INSURANCE RATES AND CONTRACTS[View Entire Chapter](#)

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) This section does not:

(a) Affect or preempt 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.

History.—s. 131, ch. 92-33; s. 9, ch. 2008-32.

¹Note.—Section 9, ch. 2008-32, provides that s. 627.6562 is amended "[e]ffective [May 21, 2008,] and applicable to policies issued or renewed on or after October 1, 2008."