Healthy Access Database

National Association of Health Underwriters

America's Benefits Specialists

Florida Information Directory

Employer-Based Health Insurance Coverage

Small Employer Groups

Definition
1-50 employees.

Requirements for Obtaining Coverage
Employers must prove carriers with copies their federal income tax Schedule K or Schedule C forms. In addition, if there is an employee or owner who is not drawing a paycheck, carriers require a letter from CPA or Attorney stating when business was formed and who works for the business and number of hours.

Guarantee Issue Requirements
As per the federal Health Insurance Portability and Accountability Act of 1996, all health insurance contracts for employer-groups of 2-50 employees must be issued on a guarantee-issue basis. All group insurance contracts must also be guarantee-renewable, unless there is non-payment of premium, the employer has committed fraud or intentional misrepresentation or the employer has not complied with the terms of the health insurance contract.

In Florida, carriers must also guarantee issue certain small-group coverage to groups-of-one during annual open enrollment periods.

Preexisting Condition Requirements
As per the federal Health Insurance Portability and Accountability Act of 1996, all group health insurance carriers can impose a 6-month look-back/12-month exclusionary period for preexisting conditions on enrollees that do not have prior creditable coverage.

Underwriting Requirements
In the small group market in Florida, there are rate restrictions are +/-15% of the indexed rate depending on the health of the group. Groups over 10 employees may use group medical questionnaire. Groups of under 10 employees must answer individual medical questionnaires. Small employer health insurance carriers may use the following rating factors: geographic area and number of employees, as well as health of the group. Renewals are capped at 15% plus trend.

Creditable Coverage Requirements
As per the federal Health Insurance Portability and Accountability Act of 1996, credit for prior coverage is required as long as there is no more than a 63-day break in coverage.

Large Employer Groups

Definition
51 or more employees.

Issuance of Coverage
Large group health insurance contracts, unlike small group health insurance contracts,

do not have to be offered on a guarantee-issue basis. Large group health insurance is medically underwritten at the time of purchase, with rates based on employee participation and prior claims experience. However, as per the federal Health Insurance Portability and Accountability Act of 1996, all group insurance contracts, including large group contracts, must be guarantee-renewable, unless there is non-payment of premium, the employer has committed fraud or intentional misrepresentation or the employer has not complied with the terms of the health insurance contract.

Creditable Coverage Requirements
As per the federal Health Insurance Portability and Accountability Act of 1996, credit for prior coverage is required as long as there is no more than a 63-day break in coverage.

Continuation of Coverage Options

COBRA
Many organizations that employ more than 20 people and offer health benefits are required to allow employees and their dependents to temporarily continue their health insurance coverage for specified time periods and under specified conditions even after they would no longer be traditionally eligible for that coverage. The federal legislation that requires this is known as the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA). This section explains people's rights under COBRA, which do not vary by state.

Qualifying Events

State Continuation and/or Individual Conversion Plans

Overview of State Continuation/Mini-COBRA Requirements
Individuals in employer groups of 2-19 individuals must, at minimum, be offered group continuation coverage for 18 months if they have a qualifying event. Qualifying event means, with respect to any covered employee, any of the following events which, but for the election of continuation coverage, would result in a loss of coverage to a qualified beneficiary: (1) The death of the covered employee, (2) The termination or reduction of hours of the covered employee's employment, except that termination of an employee for gross misconduct does not constitute a qualifying event. The employer's decision to terminate for gross misconduct is conclusive as to the carrier. (3) The divorce or legal separation of the covered employee from the covered employee's spouse. (4) A covered employee's becoming entitled to benefits under either part A or part B of Title XVIII of the Social Security Act (Medicare). (5) A dependent child's ceasing to be a dependent child under the generally applicable requirements of the group health plan. (6) A retiree or the spouse or child of a retiree losing coverage within 1 year before or after commencement of a bankruptcy proceeding under Title XI of the United States Code by the employer from whose employment the covered employee retired.

If the individual becomes disabled during the initial 18 month continuation period, the offer of coverage must be extended for an additional 11 months, if the qualified beneficiary provides the written determination of disability from the Social Security Administration to the insurance carrier within 60 days of the date of determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period.

If elected, coverage must continue until: (1) nonpayment of premium, (2) the beneficiary becomes covered under any other group health plan (unless he or she is subject to a preexisting condition requirement under that plan, (3) the individual becomes Medicare eligible, or (4) the employer terminates coverage under the group health plan for all employees. If the employer terminates coverage under the group health plan for all employees and if such group health plan is replaced by similar coverage under another group health plan, the qualified beneficiary shall have the right to become covered under the new group health plan for the

balance of the period that she or he would have remained covered under the prior group health plan.

Individuals must have at least one day of proper coverage with the group health insurance plan to be eligible, and have 30 days to elect continuation coverage by informing the insurance carrier in writing in a specified format. The premium paid for continuation of coverage may not exceed 115 percent of the applicable premium. The insurance carrier can charge up to 150 percent of the group rate during the 11-month disability extension.

Conversion Plan Requirements
Individuals who are transferring out of a group plan have the option of selecting an individual conversion product, after exhausting continuation coverage.

HIPAA Group-to Individual Portability Coverage

Explanation
Individuals who have been in enrolled in a group health plan and decide to leave that group health plan and purchase individual market coverage have certain rights under the federal Health Insurance Portability and Accountability Act of 1996. States must provide at least one guarantee-issue option for those individuals to purchase individual market insurance, as long as that coverage is purchased within 63 days of disenrollment from the group plan. Individuals who have access to COBRA must first exhaust COBRA coverage before exercising their HIPAA rights, unless specified by the state. Individuals with less than 12 months of creditable coverage may be eligible for partial credit, based on the length of creditable coverage they do have available.

Currently in Florida, individuals exercising their HIPAA rights can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers.

Exhaustion of Other Coverage Requirements
Individuals must exhaust their COBRA benefits or similar state program benefits if available to them before exercising their HIPAA rights. Individuals also cannot currently be eligible for Medicare or Medicaid or covered under any other health insurance.

Creditable Coverage Requirements
Individuals must have at least 18 months of prior creditable coverage. The most recent prior coverage must have been group health insurance coverage offered by a health insurance issuer, group health plan, government plan or church plan. Individuals may not have had a prior coverage break of more than 63 days.

Other Requirements
Individuals must be residents of Florida.

Individual Health Insurance Coverage

Traditional Private Individual Health Insurance

Underwriting Requirements
Medical underwriting is allowed without restriction.

Rating Restrictions
There are no rate caps in the Florida traditional individual health insurance market.

Issuance of Coverage
Carriers are not required to guarantee-issue coverage, except to people who are

exercising their HIPAA group-to-individual portability rights. Elimination riders are permitted, except for the HIPAA-eligible population.

Preexisting Condition Requirements
There is a 24-month look-back and exclusionary period limit for pre-existing conditions in traditional individual market health insurance products in Florida. Pre-existing conditions may not be considered for HIPAA-eligible population.

Creditable Coverage Requirements
Credit for prior coverage is required.

Coverage for Medically Uninsurable Individuals

Guarantee Issue Requirements

General
Traditional individual market health insurance is not sold on a guarantee issue basis in Florida.

HIPAA Group-to Individual Portability Coverage
Currently in Florida, individuals exercising their federal group-to-individual health insurance rights provided by the Health Insurance Portability and Accountability Act of 1996 can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers.

High-Risk Health Insurance Pools

Eligibility Criteria
The Florida pool is currently closed to new applicants and has been since 1991. Existing participants must be residents of Florida and have received from two or more health insurers: (1) a notice of rejection for substantially similar health insurance coverage; or (2) a notice of benefit reduction or specific condition exclusion; or (3) a notice of premium increase for in-force or applied for insurance exceeding the pool rate of coverage.

Overview of Benefits
The pool plan options provide comprehensive coverage of doctor visits, prescription drugs, outpatient and in-hospital care, maternity, ambulance, labs and x-rays, skilled nursing care, hospice, home health visits, transplants, rehabilitation, durable medical equipment, mental health and substance abuse, physical therapy and dental care, among other services.

Overview of Coverage Options
The pool offers PPO coverage with deductible options of $1000, $1500, $2000, $5000, and $10,000.

Preexisting Condition Requirements
No payment is allowed for services related to any accident or illness for which medical advice was given or treatment provided, recommended or advised within six months prior to the policy date. However, after the policy has been in effect for 12 months, expenses for preexisting conditions will be paid according to policy provisions.

Rate Restrictions
For 1991 and thereafter, no rate shall exceed the following average rate found in the private marketplace:

200 percent for maximum for low-risk individuals;

225 percent for medium-risk individuals; and
250 percent maximum for high-risk individuals.

Each insured's risk class is determined by his/her medical history, medical condition and anticipated claims cost.

Other State Options

Overview of State Alternative

Florida's current high-risk pool, the Florida Comprehensive Health Association has been closed to new enrollees since 1991. As such, there is no mechanism currently in place to serve new medically uninsurable individuals who do not either have access to group coverage or guarantee issue rights provided under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

However, legislation was enacted in Florida in 2004 to create the Florida Health Insurance Plan, a new high-risk pool, which would combine the existing pool with new enrollees. The development of the pool is contingent upon the creation of a funding mechanism. A legislative effort is currently underway to create a funding mechanism for the pool, so that it can become operational and accept new enrollees.

Assistance for Obtaining Health Coverage

Medicaid

Income Requirements

Children

Children (ages 1-5)-133% of the Federal Poverty Level
Children (Ages 6-19)-100% of the Federal Poverty Level

Pregnant Women and Infants

Pregnant Women-185% of the Federal Poverty Level
Infants (ages 0-1)-200% of the Federal Poverty Level

Parents

Non-Working Parents-23% of the Federal Poverty Level
Working Parents-62% of the Federal Poverty Level

Other Populations

Medically Needy Individual-25% of the Federal Poverty Level
Medically Needy Couple-25% of the Federal Poverty Level
Supplemental Security Income Recipients-74% of the Federal Poverty Level
Aged, Blind and Disabled-90% of the Federal Poverty Level

Asset Requirements

Asset and resource requirements vary based on the Medicaid program for which an individual is applying. There are no asset or resource requirements for children or pregnant mothers.

Other Enrollment Requirements

Individuals must be legal Florida residents and meet other specified program, income and asset requirements.

Overview of Benefits and Covered Services

Florida Medicaid provides coverage for at least the following services:

Advanced Registered Nurse Practitioners

Ambulatory Surgical Center
Birth Center Services
Child Health Check Up
Chiropractic Care
Durable Medical Equipment and Supplies
Federally Qualified Health Centers
Home Health
Hospital Inpatient/Outpatient Care
Laboratory
Licensed Midwifes
Physician
Physician Assistant
Podiatry
Prescriptions
Rural Health Clinics
Therapy
X-Rays

Cost Information
Depending on the program for which the individual is enrolled, he or she may be required to pay co-payments and coinsurance for some services. Co-payments range from $1-3, and coinsurance is limited to 5% up to $300 for each visit to the Emergency Room. Pregnant women, children under age 21, Medicaid managed care recipients, and hospital or nursing home patients who are expected to contribute most of their income to institutional care are exempt from cost-sharing requirements. In addition, all Medicaid beneficiaries are exempt from co-payments for emergency services and family planning services.

State Children's Health Insurance Program

Eligibility Requirements

Income Requirements
The Florida KidCare program provides coverage to children with family incomes up to 200 percent of the federal poverty level who do not qualify for Medicaid and meet the other eligibility requirements.

Other Eligibility Requirements
To qualify, a child must:
Be under age 19;
Be uninsured;
Meet income eligibility requirements;
Be a U.S. citizen or qualified non-citizen;
Not be the dependent of a state employee eligible for health insurance; and
Not be in a public institution.

Crowd-Out Requirements
For each child who is applying for Florida KidCare, parents must tell Florida KidCare if the child could be covered under a health insurance plan offered by your employer, even if the child is not covered by the employer's health insurance now, and how much it would cost each month to add the child.

A child whose health insurance was voluntarily cancelled within 6 months of an open enrollment period will not qualify for MediKids, Healthy Kids, or Children's Medical Services Network coverage.

Overview of Benefits and Covered Services
The Florida KidCare program provides participants with comprehensive health insurance coverage. Benefits vary based on the segment of the program in which a child participates--MediKids, Healthy Kids, or the Children's Medical Services (CMS) Network

for children with special health care needs.

Integration with Employer-Based Coverage
There is no integration with a parent's potential employer-sponsored health insurance coverage in Florida a t this time.

If a child has access to employer-sponsored coverage, they are still eligible for KidCare coverage if their private coverage option costs more than five percent of family income.

Parental Benefits
There are no parental benefits under the Florida KidCare program at this time.

Cost Information
The amount of the KidCare premium is based on household size and monthly income. Most families pay either $15 or $20 per family per month; some families may pay more. There may be co-payments required based on the service provided.

Federal Health Care Tax Credit Program

Eligibility Requirements and Rights
This section provides detailed information about eligibility for the HCTC Program.

Purchasing Options

COBRA
Individuals can use federal Health Care Tax Credit funds to pay for COBRA continuation coverage, as long as the employer or former employer contributes less than 50% of the total health plan premium.

The COBRA Provisions only apply to federally mandated COBRA continuation coverage, which applies to employer-groups who employed 20 or employees in the prior year, and requires them to provide the option of temporarily continuing group coverage to individuals when their group health coverage is lost due to certain specific events. State continuation coverage mandates, which may apply to smaller group health plans may not necessarily be an approved mechanism to spend federal Health Care Tax Credit funds. Individuals also may not use Health Care Tax Credit funds to pay for employer-sponsored premiums if the employer is voluntarily providing some type of continuation benefit that is not the same as federally mandated COBRA.

Qualified Spouse's Plan
Individuals can use federal Health Care Tax Credit funds to pay for employer-sponsored health insurance they receive through their spouse's employer, provided that the employer pays no more than 50% of the total family premium (which includes any amount that the employer pays for the spouse's coverage).

Qualified Individual Health Insurance Coverage
Individuals can use federal Health Care Tax Credit funds to pay for private individual heath insurance coverage, provided that they were enrolled in such coverage for at least the last 30 days before they were separated from the job that makes them eligible for TAA benefits or for payments from the Pension Benefit Guarantee Corporation.

State-Elected Option(s)
In Florida, individuals who are eligible for the federal Health Care Tax Credit can also use their credit funds to purchase specified private coverage through Blue Cross Blue Shield of Florida.

Individuals who worked for employers that are not required to provide federally

mandated COBRA continuation coverage, but did work for employers that are required to abide by the state's continuation of coverage law, can also use their credit funds to purchase private continuation coverage through their previous employer.