

By the Committee on Health Care Services and Representatives Albright, Geller, Arnall, Casey, Bloom, Peadar, Heyman, Rodriguez-Chomat, Byrd, Flanagan, Goode and Littlefield

1 A bill to be entitled
2 An act relating to health insurance; amending
3 s. 624.91, F.S.; limiting the time of
4 participation in the Health Kids Corporation;
5 amending s. 627.6406, F.S., relating to
6 coverage for maternity care; prohibiting an
7 insurer from imposing certain limitations on
8 benefits, coverage, or reimbursement; amending
9 s. 627.6425, F.S.; requiring an insurer that
10 provides individual coverage to renew or
11 continue coverage; providing certain
12 exceptions; requiring an insurer to provide
13 notice of discontinuation; authorizing an
14 insurer to modify coverage; revising
15 requirements for renewability of individual
16 coverage; creating s. 627.6475, F.S.; providing
17 for an individual reinsurance pool; providing
18 purpose; providing definitions; providing
19 applicability and scope; providing requirements
20 for availability of coverage; requiring
21 maintenance of records; providing an election
22 for carriers; providing an election process;
23 requiring operations of the program to be
24 subject to the board of the Florida Small
25 Employer Reinsurance Program; requiring the
26 establishment of a separate account; providing
27 for standards to assure fair marketing;
28 authorizing the Department of Insurance to
29 adopt rules; creating s. 627.6487, F.S.;
30 providing for guaranteed availability of health
31 insurance coverage to eligible individuals;

1 prohibiting an insurer or health maintenance
2 organization from declining coverage for
3 eligible individuals or imposing preexisting
4 conditions; providing definitions; providing
5 certain exceptions; creating s. 627.64871,
6 F.S.; providing for application of requirements
7 for certification of coverage; providing
8 exceptions; creating s. 627.6489, F.S.;
9 authorizing the Florida Comprehensive Health
10 Association to contract with insurers to
11 provide disease management services; creating
12 s. 627.6512, F.S.; exempting certain group
13 health insurance policies from specified
14 requirements with respect to excepted benefits;
15 amending s. 627.6561, F.S., relating to
16 exclusions for preexisting conditions;
17 providing definitions; specifying circumstances
18 under which an insurer may impose an exclusion
19 for a preexisting condition; providing
20 exceptions; providing requirements for
21 creditable coverage; providing for an election
22 of methods for calculating creditable coverage;
23 requiring disclosure of certain elections;
24 providing for establishing creditable coverage;
25 providing exceptions; requiring an issuer to
26 provide certification pursuant to rules adopted
27 by the department; creating s. 627.65615, F.S.;
28 providing for special enrollment periods for
29 employees and dependents; specifying conditions
30 for special enrollment periods; creating s.
31 627.65625, F.S.; prohibiting an insurer from

1 discriminating against individual participants
2 and beneficiaries based on health status;
3 creating s. 627.6571, F.S.; specifying
4 circumstances under which an insurer that
5 issues group health insurance policies must
6 renew or continue coverage; providing for
7 notice of discontinuation; providing a process
8 for notification; authorizing an insurer to
9 modify coverage; amending s. 627.6574, F.S.,
10 relating to coverage for maternity care;
11 prohibiting a group, blanket, or franchise
12 policy from imposing certain limitations on
13 enrolling or renewing coverage; prohibiting an
14 insurer from imposing certain limitations on
15 benefits, coverage, or reimbursement;
16 prohibiting an insurer from providing monetary
17 payments or rebates; amending s. 627.6675,
18 F.S.; revising time limitations for application
19 for and payment of a converted policy;
20 requiring an insurer to offer a standard health
21 benefit plan; amending s. 627.6699, F.S.,
22 relating to the Employee Health Care Access
23 Act; revising definitions; providing
24 requirements for policies with respect to
25 preexisting conditions; providing exceptions;
26 requiring special enrollment periods;
27 authorizing a small carrier to deny coverage
28 under certain circumstances; revising
29 requirements for renewing coverage; increasing
30 membership of the board of the Small Employer
31 Health Reinsurance Program; requiring a small

1 employer to disclose certain information with
2 respect to a health benefit plan; amending s.
3 627.9404, F.S.; providing additional
4 definitions; amending s. 627.9407, F.S.;
5 specifying additional information required to
6 be disclosed for purposes of long-term care
7 insurance; requiring a disclosure statement;
8 amending s. 627.94071, F.S.; specifying
9 additional minimum standards for home health
10 care benefits; amending s. 627.94072, F.S.;
11 deleting a requirement to provide cash
12 surrender values in offering long-term care
13 insurance policies; amending s. 627.94073,
14 F.S.; revising notice of cancellation
15 provisions; amending s. 627.94074, F.S.;
16 revising standards for benefit triggers;
17 creating s. 641.2018, F.S.; authorizing a
18 health maintenance organization to offer high
19 deductible contracts to certain employers;
20 amending s. 641.31, F.S.; revising requirements
21 for a health maintenance contract that provides
22 coverage for maternity care; prohibiting a
23 health maintenance organization from denying
24 eligibility to enroll or to renew coverage;
25 prohibiting such an organization from imposing
26 certain limitations on benefits, coverage, or
27 reimbursement; prohibiting such an organization
28 from providing monetary payments or rebates;
29 amending s. 641.3102, F.S.; prohibiting health
30 maintenance organizations from declining to
31 offer coverage to an eligible individual under

1 s. 627.6487, F.S.; creating s. 641.31071, F.S.,
2 relating to exclusions for preexisting
3 conditions; providing definitions; specifying
4 circumstances under which a health maintenance
5 organization may impose an exclusion for a
6 preexisting condition; providing exceptions;
7 providing requirements for creditable coverage;
8 providing for an election of methods for
9 calculating creditable coverage; requiring
10 disclosure of certain elections; providing for
11 establishing creditable coverage; providing
12 exceptions; requiring a health maintenance
13 organization to provide certification pursuant
14 to rules adopted by the department; creating s.
15 641.31072, F.S.; requiring a health maintenance
16 organization to provide for special enrollment
17 periods under a contract for employees and
18 dependents; providing conditions for special
19 enrollment periods; creating s. 641.31073,
20 F.S.; prohibiting a health maintenance
21 organization from discriminating against
22 individual participants and beneficiaries based
23 on health status; creating s. 641.31074, F.S.;
24 requiring a health maintenance organization to
25 renew or continue coverage of certain group
26 health insurance contracts; requiring notice of
27 discontinuation; prescribing a process for
28 notification; authorizing a health maintenance
29 organization to modify coverage; amending s.
30 641.3921, F.S.; clarifying circumstances under
31 which a health maintenance organization may

1 issue a converted contract; amending s.
2 641.3922, F.S.; revising the time limitation
3 for applying for a converted contract; revising
4 the maximum premium rate for a converted
5 contract; requiring a health maintenance
6 organization to offer a standard health benefit
7 plan; providing that the act fulfills an
8 important state interest; repealing s.
9 627.6576, F.S., relating to a prohibition
10 against discriminating against handicapped
11 persons under policies of group, blanket, or
12 franchise health insurance; providing for
13 application of the act; requiring certain
14 legislative committees to conduct a study for
15 certain purposes and make recommendations to
16 the Legislature; requiring the Department of
17 Insurance to provide assistance; providing for
18 application of the act with respect to a plan
19 or contract maintained pursuant to a collective
20 bargaining agreement; providing an effective
21 date.

22
23 Be It Enacted by the Legislature of the State of Florida:

24
25 Section 1. Paragraph (b) of subsection (3) of section
26 624.91, Florida Statutes, 1996 Supplement, is amended to read:

27 624.91 The Florida Healthy Kids Corporation Act.--

28 (3) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

29 (b) The Florida Healthy Kids Corporation shall phase
30 in a program to:

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- 1 1. Organize school children groups to facilitate the
2 provision of preventive health care services to children and
3 to provide comprehensive health insurance coverage to
4 children;
- 5 2. Arrange for the collection of any family or
6 employer payment or premium, in an amount to be determined by
7 the board of directors, from all participant families or
8 employers to provide for payment for preventive health care
9 services or premiums for comprehensive insurance coverage and
10 for the actual or estimated administrative expenses incurred
11 during the period for which family or employer payments are
12 made;
- 13 3. Establish the administrative and accounting
14 procedures for the operation of the corporation;
- 15 4. Establish, with consultation from appropriate
16 professional organizations, standards for preventive health
17 services and providers and comprehensive insurance benefits
18 appropriate to children;
- 19 5. Establish eligibility criteria which children must
20 meet in order to participate in the program, provided such
21 criteria shall include a maximum 60-month limitation on
22 lifetime participation in the program by any child who first
23 enrolls in the program after July 1, 1997;
- 24 6. Establish procedures under which applicants to and
25 participants in the program may have grievances reviewed by an
26 impartial body and reported to the board of directors of the
27 corporation;
- 28 7. Establish participation criteria and, if
29 appropriate, contract with an authorized insurer, health
30 maintenance organization, or insurance administrator to
31 provide administrative services to the corporation;

1 8. Contract with authorized insurers or any provider
2 of health care services, meeting standards established by the
3 corporation, for the provision of comprehensive insurance
4 coverage and preventive health care services to participants;

5 9. Develop and implement a plan to publicize the
6 Florida Healthy Kids Corporation, the eligibility requirements
7 of the program, and the procedures for enrollment in the
8 program and to maintain public awareness of the corporation
9 and the program;

10 10. Secure staff necessary to properly administer the
11 corporation. Staff costs shall be funded from state and local
12 matching funds and such other private or public funds as
13 become available. The board of directors shall determine the
14 number of staff members necessary to administer the
15 corporation;

16 11. As appropriate, enter into contracts with local
17 school boards or other agencies to provide onsite information,
18 enrollment, and other services necessary to the operation of
19 the corporation; and

20 12. Provide a report on an annual basis to the
21 Governor, Insurance Commissioner, Commissioner of Education,
22 Senate President, Speaker of the House of Representatives, and
23 Minority Leaders of the Senate and the House of
24 Representatives.

25 13. For the 1996-1997 fiscal year only, funds may be
26 appropriated to the Florida Healthy Kids Corporation to
27 organize school children groups to facilitate the provision of
28 preventive health care services to children at sites in
29 addition to those allowed in subparagraph 1. This
30 subparagraph is repealed on July 1, 1997.

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1 Section 2. Section 627.6406, Florida Statutes, 1996
2 Supplement, is amended to read:

3 627.6406 Maternity care.--

4 (1) Any policy of health insurance that provides
5 coverage for maternity care must ~~shall~~ also cover the services
6 of certified nurse-midwives and midwives licensed pursuant to
7 chapter 467, and the services of birth centers licensed under
8 ss. 383.30-383.335.

9 (2) An insurer issuing a health insurance policy that
10 ~~which~~ provides maternity and newborn coverage may not limit
11 coverage for the length of a maternity and newborn stay in a
12 hospital or for followup care outside of a hospital to any
13 time period that is less than that determined to be medically
14 necessary, in accordance with prevailing medical standards and
15 consistent with ~~proposed 1996~~ guidelines for perinatal care of
16 the American Academy of Pediatrics or the American College of
17 Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by
18 the treating obstetrical care provider or the pediatric care
19 provider.

20 (3) ~~Nothing in~~ This section does not affect ~~affects~~
21 any agreement between an insurer and a hospital or other
22 health care provider with respect to reimbursement for health
23 care services provided, rate negotiations with providers, or
24 capitation of providers, and this section does not prohibit ~~or~~
25 ~~prohibits~~ appropriate utilization review or case management by
26 an insurer.

27 (4) Any policy of health insurance that provides
28 coverage, benefits, or services for maternity or newborn care
29 must provide coverage for postdelivery care for a mother and
30 her newborn infant. The postdelivery care must include a
31 postpartum assessment and newborn assessment and may be

1 provided at the hospital, at the attending physician's office,
2 at an outpatient maternity center, or in the home by a
3 qualified licensed health care professional trained in mother
4 and baby care. The services must include physical assessment
5 of the newborn and mother, and the performance of any
6 medically necessary clinical tests and immunizations in
7 keeping with prevailing medical standards.

8 (5) An insurer subject to subsection (1) shall
9 communicate active case questions and concerns regarding
10 postdelivery care directly to the treating physician or
11 hospital in written form, in addition to other forms of
12 communication. Such insurers shall also use a process that
13 ~~which~~ includes a written protocol for utilization review and
14 quality assurance.

15 (6) An insurer subject to subsection (1) may not:

16 (a) Deny to a mother or her newborn infant
17 eligibility, or continued eligibility, to enroll or to renew
18 coverage under the terms of the policy for the purpose of
19 avoiding the requirements of this section.

20 (b) Provide monetary payments or rebates to a mother
21 to encourage the mother to accept less than the minimum
22 protections available under this section.

23 (c) Penalize or otherwise reduce or limit the
24 reimbursement of an attending provider solely because the
25 attending provider provided care to an individual participant
26 or beneficiary in accordance with this section.

27 (d) Provide incentives, monetary or otherwise, to an
28 attending provider solely to induce the provider to provide
29 care to an individual participant or beneficiary in a manner
30 inconsistent with this section.

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1 (e) Subject to paragraph (7)(c), restrict benefits for
2 any portion of a period within a hospital length of stay
3 required under subsection (2) in a manner that is less
4 favorable than the benefits provided for any preceding portion
5 of such stay.

6 (7)(a) This section does not require a mother who is a
7 participant or beneficiary to:

8 1. Give birth in a hospital.

9 2. Stay in the hospital for a fixed period of time
10 following the birth of her infant.

11 (b) This section does not apply with respect to any
12 health insurance coverage that does not provide benefits for
13 hospital lengths of stay in connection with childbirth for a
14 mother or her newborn infant.

15 (c) This section does not prevent a policy from
16 imposing deductibles, coinsurance, or other cost-sharing in
17 relation to benefits for hospital lengths of stay in
18 connection with childbirth for a mother or her newborn infant,
19 except that such coinsurance or other cost-sharing for any
20 portion of a period within a hospital length of stay required
21 under subsection (2) may not be greater than such coinsurance
22 or cost-sharing for any preceding portion of such stay.

23 Section 3. Section 627.6425, Florida Statutes, 1996
24 Supplement, is amended to read:

25 (Substantial rewording of section. See
26 s. 627.6425, F.S., 1996 Supp., for present text.)
27 627.6425 Renewability of individual coverage.--

28 (1) Except as otherwise provided in this section, an
29 insurer that provides individual health insurance coverage to
30 an individual shall renew or continue in force such coverage
31 at the option of the individual. For the purpose of this

1 section, the term "individual health insurance" means health
2 insurance coverage, as described in s. 627.6561(5)(a)2.,
3 offered to an individual in this state, including certificates
4 of coverage offered to individuals in this state as part of a
5 group policy issued to an association outside this state, but
6 the term does not include short-term limited duration
7 insurance or excepted benefits specified in subsection (6) or
8 subsection (7).

9 (2) An insurer may nonrenew or discontinue health
10 insurance coverage of an individual in the individual market
11 based only on one or more of the following:

12 (a) The individual has failed to pay premiums or
13 contributions in accordance with the terms of the health
14 insurance coverage or the insurer has not received timely
15 premium payments.

16 (b) The individual has performed an act or practice
17 that constitutes fraud or made an intentional
18 misrepresentation of material fact under the terms of the
19 coverage.

20 (c) The insurer is ceasing to offer coverage in the
21 individual market in accordance with subsection (3) and
22 applicable state law.

23 (d) In the case of a health insurer that offers health
24 insurance coverage in the market through a network plan, the
25 individual no longer resides, lives, or works in the service
26 area, or in an area for which the insurer is authorized to do
27 business, but only if such coverage is terminated under this
28 paragraph uniformly without regard to any
29 health-status-related factor of covered individuals.

30 (e) In the case of health insurance coverage that is
31 made available in the individual market only through one or

1 more bona fide associations, as defined in s. 627.6571(5), the
2 membership of the individual in the association, on the basis
3 of which the coverage is provided, ceases, but only if such
4 coverage is terminated under this paragraph uniformly without
5 regard to any health-status-related factor of covered
6 individuals.

7 (3)(a) In any case in which an insurer decides to
8 discontinue offering a particular policy form for health
9 insurance coverage offered in the individual market, coverage
10 under such form may be discontinued by the insurer only if:

11 1. The insurer provides notice to each covered
12 individual provided coverage under this policy form in the
13 individual market of such discontinuation at least 90 days
14 prior to the date of the discontinuation of such coverage;

15 2. The insurer offers to each individual in the
16 individual market provided coverage under this policy form the
17 option to purchase any other individual health insurance
18 coverage currently being offered by the insurer for
19 individuals in such market in the state; and

20 3. In exercising the option to discontinue coverage of
21 this policy form and in offering the option of coverage under
22 subparagraph 2., the insurer acts uniformly without regard to
23 any health-status-related factor of enrolled individuals or
24 individuals who may become eligible for such coverage.

25 (b)1. Subject to subparagraph (a)3., in any case in
26 which an insurer elects to discontinue offering all health
27 insurance coverage in the individual market in this state,
28 health insurance coverage may be discontinued by the insurer
29 only if:

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1 a. The insurer provides notice to the department and
2 to each individual of such discontinuation at least 180 days
3 prior to the date of the expiration of such coverage; and

4 b. All health insurance issued or delivered for
5 issuance in the state in the individual market is discontinued
6 and coverage under such health insurance coverage in such
7 market is not renewed.

8 2. In the case of a discontinuation under subparagraph
9 1. in the individual market, the insurer may not provide for
10 the issuance of any individual health insurance coverage in
11 this state during the 5-year period beginning on the date of
12 the discontinuation of the last health insurance coverage not
13 so renewed.

14 (4) At the time of coverage renewal, an insurer may
15 modify the health insurance coverage for a policy form offered
16 to individuals in the individual market so long as such
17 modification is consistent with the laws of this state and
18 effective on a uniform basis among all individuals with that
19 policy form.

20 (5) In applying this section in the case of health
21 insurance coverage that is made available by an insurer in the
22 individual market to individuals only through one or more
23 associations, a reference to an "individual" includes a
24 reference to such an association of which the individual is a
25 member.

26 (6) The requirements of this section do not apply to
27 any health insurance coverage in relation to its provision of
28 excepted benefits described in s. 627.6561(5)(b).

29 (7) The requirements of this section do not apply to
30 any health insurance coverage in relation to its provision of
31 excepted benefits described in s. 627.6561(5)(c), (d), or (e),

1 if the benefits are provided under a separate policy,
2 certificate, or contract of insurance.

3 (8) This section applies to health insurance coverage
4 offered, sold, issued, or renewed in the individual market on
5 or after July 1, 1997.

6 Section 4. Section 627.6475, Florida Statutes, is
7 created to read:

8 627.6475 Individual reinsurance pool.--

9 (1) PURPOSE.--The purpose of this section is to
10 provide for the establishment of a reinsurance program for
11 coverage of individuals who are eligible for issuance of
12 individual health insurance from a health insurance issuer
13 pursuant to s. 627.6487.

14 (2) DEFINITIONS.--As used in this section:

15 (a) "Board," "carrier," and "health benefit plan" have
16 the same meaning ascribed in s. 627.6699(3).

17 (b) "Health insurance issuer," "issuer," and
18 "individual health insurance" have the same meaning ascribed
19 in s. 627.6487(2).

20 (c) "Reinsuring carrier" means a health insurance
21 issuer that elects to comply with the requirements set forth
22 in subsection (7).

23 (d) "Risk-assuming carrier" means a health insurance
24 issuer that elects to comply with the requirements set forth
25 in subsection (6).

26 (e) "Eligible individual" has the same meaning
27 ascribed in s. 627.6487(3).

28 (3) APPLICABILITY AND SCOPE.--This section applies to
29 individual health insurance offered by a health insurance
30 issuer to an eligible individual.

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1 (4) MAINTENANCE OF RECORDS.--Each health insurance
2 issuer that offers individual health insurance must maintain
3 at its principal place of business a complete and detailed
4 description of its rating practices and renewal practices, as
5 required for small employer carriers pursuant to s.
6 627.6699(8).

7 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING
8 CARRIER.--

9 (a) Each health insurance issuer that offers
10 individual health insurance must elect to become a
11 risk-assuming carrier or a reinsuring carrier for purposes of
12 this section. Each such issuer must make an initial election,
13 binding through December 31, 1999. The issuer's initial
14 election must be made no later than October 31, 1997. By
15 October 31, 1997, all issuers must file a final election,
16 which is binding for 2 years, from January 1, 1998, through
17 December 31, 1999, after which an election shall be binding
18 for a period of 5 years. The department may permit an issuer
19 to modify its election at any time for good cause shown, after
20 a hearing.

21 (b) The department shall establish an application
22 process for issuers seeking to change their status under this
23 subsection.

24 (c) An election to become a risk-assuming carrier is
25 subject to approval under this subsection.

26 (d) An issuer that elects to cease participating as a
27 reinsuring carrier and to become a risk-assuming carrier may
28 not reinsure or continue to reinsure any individual health
29 benefits plan under subsection (7) once the issuer becomes a
30 risk-assuming carrier, and the issuer must pay a prorated
31 assessment based upon business issued as a reinsuring carrier

1 for any portion of the year that the business was reinsured.
2 An issuer that elects to cease participating as a
3 risk-assuming carrier and to become a reinsuring carrier may
4 reinsure individual health insurance under the terms set forth
5 in subsection (7) and must pay a prorated assessment based
6 upon business issued as a reinsuring carrier for any portion
7 of the year that the business was reinsured.

8 (6) ELECTION PROCESS TO BECOME A RISK-ASSUMING
9 CARRIER.--

10 (a)1. A health insurance issuer that offers individual
11 health insurance may become a risk-assuming carrier by filing
12 with the department a designation of election under this
13 subsection in a format and manner prescribed by the
14 department. The department shall approve the election of a
15 health insurance issuer to become a risk-assuming carrier if
16 the department finds that the issuer is capable of assuming
17 that status pursuant to the criteria set forth in paragraph
18 (b).

19 2. The department must approve or disapprove any
20 designation as a risk-assuming carrier within 60 days after a
21 filing.

22 (b) In determining whether to approve an application
23 by an issuer to become a risk-assuming carrier, the department
24 shall consider:

25 1. The issuer's financial ability to support the
26 assumption of the risk of individuals.

27 2. The issuer's history of rating and underwriting
28 individuals.

29 3. The issuer's commitment to market fairly to all
30 individuals in the state or its service area, as applicable.

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1 4. The issuer's ability to assume and manage the risk
2 of enrolling individuals without the protection of the
3 reinsurance program provided in subsection (7).

4 (c) The department shall provide public notice of an
5 issuer's designation of election under this subsection to
6 become a risk-assuming carrier and shall provide at least a
7 21-day period for public comment prior to making a decision on
8 the election. The department shall hold a hearing on the
9 election at the request of the issuer.

10 (d) The department may rescind the approval granted to
11 a risk-assuming carrier under this subsection if the
12 department finds that the carrier no longer meets the criteria
13 of paragraph (b).

14 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

15 (a) The individual health reinsurance program shall
16 operate subject to the supervision and control of the board of
17 the small employer health reinsurance program established
18 pursuant to s. 627.6699(11). The board shall establish a
19 separate, segregated account for eligible individuals
20 reinsured pursuant to this section, which account may not be
21 commingled with the small employer health reinsurance account.

22 (b) A reinsuring carrier may reinsure with the program
23 coverage of an eligible individual, subject to each of the
24 following provisions:

25 1. A reinsuring carrier may reinsure an eligible
26 individual within 60 days after commencement of the coverage
27 of the eligible individual.

28 2. The program may not reimburse a participating
29 carrier with respect to the claims of a reinsured eligible
30 individual until the carrier has paid incurred claims of at
31 least \$5,000 in a calendar year for benefits covered by the

1 program. In addition, the reinsuring carrier is responsible
2 for 10 percent of the next \$50,000 and 5 percent of the next
3 \$100,000 of incurred claims during a calendar year, and the
4 program shall reinsure the remainder.

5 3. The board shall annually adjust the initial level
6 of claims and the maximum limit to be retained by the carrier
7 to reflect increases in costs and utilization within the
8 standard market for health benefit plans within the state. The
9 adjustment may not be less than the annual change in the
10 medical component of the "Commerce Price Index for All Urban
11 Consumers" of the Bureau of Labor Statistics of the United
12 States Department of Labor, unless the board proposes and the
13 department approves a lower adjustment factor.

14 4. A reinsuring carrier may terminate reinsurance for
15 all reinsured eligible individuals on any plan anniversary.

16 5. The premium rate charged for reinsurance by the
17 program to a health maintenance organization that is approved
18 by the Secretary of Health and Human Services as a federally
19 qualified health maintenance organization pursuant to 42
20 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
21 requirements that limit the amount of risk that may be ceded
22 to the program, which requirements are more restrictive than
23 subparagraph 2., shall be reduced by an amount equal to that
24 portion of the risk, if any, which exceeds the amount set
25 forth in subparagraph 2., which may not be ceded to the
26 program.

27 6. The board may consider adjustments to the premium
28 rates charged for reinsurance by the program or carriers that
29 use effective cost-containment measures, including high-cost
30 case management, as defined by the board.

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1 7. A reinsuring carrier shall apply its
2 case-management and claims-handling techniques, including, but
3 not limited to, utilization review, individual case
4 management, preferred provider provisions, other managed-care
5 provisions, or methods of operation consistently with both
6 reinsured business and nonreinsured business.

7 (c)1. The board, as part of the plan of operation,
8 shall establish a methodology for determining premium rates to
9 be charged by the program for reinsuring eligible individuals
10 pursuant to this section. The methodology must include a
11 system for classifying individuals which reflects the types of
12 case characteristics commonly used by carriers in this state.
13 The methodology must provide for the development of basic
14 reinsurance premium rates, which shall be multiplied by the
15 factors set for them in this paragraph to determine the
16 premium rates for the program. The basic reinsurance premium
17 rates shall be established by the board, subject to the
18 approval of the department, and shall be set at levels that
19 reasonably approximate gross premiums charged to eligible
20 individuals for individual health insurance by health
21 insurance issuers. The premium rates set by the board may vary
22 by geographical area, as determined under this section, to
23 reflect differences in cost. An eligible individual may be
24 reinsured for a rate that is five times the rate established
25 by the board.

26 2. The board shall periodically review the methodology
27 established, including the system of classification and any
28 rating factors, to ensure that it reasonably reflects the
29 claims experience of the program. The board may propose
30 changes to the rates that are subject to the approval of the
31 department.

1 (d) If individual health insurance for an eligible
2 individual is entirely or partially reinsured with the program
3 pursuant to this section, the premium charged to the eligible
4 individual for any rating period for the coverage issued must
5 be the same premium that would have been charged to that
6 individual if the health insurance issuer elected not to
7 reinsure coverage for that individual.

8 (e)1. Before March 1 of each calendar year, the board
9 shall determine and report to the department the program net
10 loss in the individual account for the previous year,
11 including administrative expenses for that year and the
12 incurred losses for that year, taking into account investment
13 income and other appropriate gains and losses.

14 2. Any net loss in the individual account for the year
15 shall be recouped by assessing the carriers as follows:

16 a. The operating losses of the program shall be
17 assessed in the following order subject to the specified
18 limitations. The first tier of assessments shall be made
19 against reinsuring carriers in an amount that may not exceed 5
20 percent of each reinsuring carrier's premiums for individual
21 health insurance. If such assessments have been collected and
22 additional moneys are needed, the board shall make a second
23 tier of assessments in an amount that may not exceed 0.5
24 percent of each carrier's health benefit plan premiums.

25 b. Except as provided in paragraph (f), risk-assuming
26 carriers are exempt from all assessments authorized pursuant
27 to this section. The amount paid by a reinsuring carrier for
28 the first tier of assessments shall be credited against any
29 additional assessments made.

30 c. The board shall equitably assess reinsuring
31 carriers for operating losses of the individual account based

1 on market share. The board shall annually assess each carrier
2 a portion of the operating losses of the individual account.
3 The first tier of assessments shall be determined by
4 multiplying the operating losses by a fraction, the numerator
5 of which equals the reinsuring carrier's earned premium
6 pertaining to direct writings of individual health insurance
7 in the state during the calendar year for which the assessment
8 is levied, and the denominator of which equals the total of
9 all such premiums earned by reinsuring carriers in the state
10 during that calendar year. The second tier of assessments
11 shall be based on the premiums that all carriers, except
12 risk-assuming carriers, earned on all health benefit plans
13 written in this state. The board may levy interim assessments
14 against reinsuring carriers to ensure the financial ability of
15 the plan to cover claims expenses and administrative expenses
16 paid or estimated to be paid in the operation of the plan for
17 the calendar year prior to the association's anticipated
18 receipt of annual assessments for that calendar year. Any
19 interim assessment is due and payable within 30 days after
20 receipt by a carrier of the interim assessment notice. Interim
21 assessment payments shall be credited against the carrier's
22 annual assessment. Health benefit plan premiums and benefits
23 paid by a carrier that are less than an amount determined by
24 the board to justify the cost of collection may not be
25 considered for purposes of determining assessments.

26 d. Subject to the approval of the department, the
27 board shall adjust the assessment formula for reinsuring
28 carriers that are approved as federally qualified health
29 maintenance organizations by the Secretary of Health and Human
30 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,
31

1 if any, that restrictions are placed on them which are not
2 imposed on other carriers.

3 3. Before March 1 of each year, the board shall
4 determine and file with the department an estimate of the
5 assessments needed to fund the losses incurred by the program
6 in the individual account for the previous calendar year.

7 4. If the board determines that the assessments needed
8 to fund the losses incurred by the program in the individual
9 account for the previous calendar year will exceed the amount
10 specified in subparagraph 2., the board shall evaluate the
11 operation of the program and report its findings and
12 recommendations to the department in the format established in
13 s. 627.6699(11) for the comparable report for the small
14 employer reinsurance program.

15 (f) Notwithstanding paragraph (e), the administrative
16 expenses of the program shall be recouped by assessing
17 risk-assuming carriers and reinsuring carriers, and such
18 amounts may not be considered part of the operating losses of
19 the plan for the purposes of this paragraph. Each carrier's
20 portion of such administrative expenses shall be determined by
21 multiplying the total of such administrative expenses by a
22 fraction, the numerator of which equals the carrier's earned
23 premium pertaining to direct writing of individual health
24 benefit plans in the state during the calendar year for which
25 the assessment is levied, and the denominator of which equals
26 the total of such premiums earned by all carriers in the state
27 during such calendar year.

28 (g) Except as otherwise provided in this section, the
29 board and the department shall have all powers, duties, and
30 responsibilities with respect to carriers that issue and
31 reinsure individual health insurance, as specified for the

1 board and the department in s. 627.6699(11) with respect to
2 small employer carriers, including, but not limited to, the
3 provisions of s. 627.6699(11) relating to:
4 1. Use of assessments that exceed the amount of actual
5 losses and expenses.
6 2. The annual determination of each carrier's
7 proportion of the assessment.
8 3. Interest for late payment of assessments.
9 4. Authority for the department to approve deferment
10 of an assessment against a carrier.
11 5. Limited immunity from legal actions or carriers.
12 6. Development of standards for compensation to be
13 paid to agents. Such standards shall be limited to those
14 specifically enumerated in s. 627.6699(13)(d).
15 7. Monitoring compliance by carriers with this
16 section.
17 (8) STANDARDS TO ASSURE FAIR MARKETING.--
18 (a) Each health insurance issuer that offers
19 individual health insurance shall actively market coverage to
20 eligible individuals in the state. The provisions of s.
21 627.6699(13) that apply to small employer carriers that market
22 policies to small employers shall also apply to health
23 insurance issuers that offer individual health insurance with
24 respect to marketing policies to individuals.
25 (b) A violation of this section by a health insurance
26 issuer or an agent is an unfair trade practice under s.
27 626.9541 or ss. 641.3903 and 641.3907.
28 (9) RULEMAKING AUTHORITY.--The department may adopt
29 rules to administer this section, including rules governing
30 compliance by carriers.
31

1 Section 5. Section 627.6487, Florida Statutes, is
2 created to read:

3 627.6487 Guaranteed availability of individual health
4 insurance coverage to eligible individuals.--

5 (1) Subject to the requirements of this section, each
6 health insurance issuer that offers individual health
7 insurance coverage in this state may not, with respect to an
8 eligible individual who desires to enroll in individual health
9 insurance coverage:

10 (a) Decline to offer such coverage to, or deny
11 enrollment of, such individual; or

12 (b) Impose any preexisting condition exclusion with
13 respect to such coverage. For purposes of this section, the
14 term "preexisting condition" means, with respect to coverage,
15 a limitation of benefits relating to a condition based on the
16 fact that the condition was present before the date of
17 enrollment for such coverage, whether or not any medical
18 advice, diagnosis, care, or treatment was recommended or
19 received before such date.

20 (2) For the purposes of this section:

21 (a) "Health insurance issuer" and "issuer" mean an
22 authorized insurer or a health maintenance organization.

23 (b) "Individual health insurance" means health
24 insurance, as defined in s. 627.6561(5)(a)2., which is offered
25 to an individual, including certificates of coverage offered
26 to individuals in this state as part of a group policy issued
27 to an association outside this state, but the term does not
28 include short-term limited duration insurance or excepted
29 benefits specified in s. 624.6561(5)(b) or, if the benefits
30 are provided under a separate policy, certificate, or
31

1 contract, the term does not include excepted benefits
2 specified in s. 627.6561(5)(c), (d), or (e).

3 (3) For the purposes of this section, the term
4 "eligible individual" means an individual:

5 (a)1. For whom, as of the date on which the individual
6 seeks coverage under this section, the aggregate of the
7 periods of creditable coverage, as defined in s. 627.6561(5)
8 and (6), is 18 or more months; and

9 2. Whose most recent prior creditable coverage was
10 under a group health plan, governmental plan, or church plan,
11 or health insurance coverage offered in connection with any
12 such plan;

13 (b) Who is not eligible for coverage under:

14 1. A group health plan, as defined in section 2791, of
15 the Public Health Service Act;

16 2. A conversion policy under s. 627.6675 or s.
17 641.3921;

18 3. Medicare, part A or part B of Title XVIII of the
19 Social Security Act as amended; or

20 4. A state plan under Medicaid, Title XIX of the
21 Social Security Act, as amended, or any successor program,

22
23 and does not have other health insurance coverage;

24 (c) With respect to whom the most recent coverage
25 within the coverage period described in paragraph (1)(a) was
26 not terminated based on a factor described in s.
27 627.6571(2)(a) or (b), relating to nonpayment of premiums or
28 fraud, unless such nonpayment of premiums or fraud was due to
29 acts of an employer or person other than the individual;

30
31

1 (d) Who, having been offered the option of
2 continuation coverage under a COBRA continuation provision or
3 under s. 627.6692, elected such coverage; and

4 (e) Who, if the individual elected such continuation
5 provision, has exhausted such continuation coverage under such
6 provision or program.

7 (4)(a) The health insurance issuer may elect to limit
8 the coverage offered under subsection (1) if the issuer offers
9 at least two different policy forms of health insurance
10 coverage, both of which:

11 1. Are designed for, made generally available to,
12 actively marketed to, and enroll both eligible and other
13 individuals by the issuer; and

14 2. Meet the requirement of paragraph (b).

15
16 For purposes of this subsection, policy forms that have
17 different cost-sharing arrangements or different riders are
18 considered to be different policy forms.

19 (b) The requirement of this subsection is met for
20 health insurance coverage policy forms offered by an issuer in
21 the individual market if the issuer offers the policy forms
22 for individual health insurance coverage with the largest, and
23 next to largest, premium volume of all such policy forms
24 offered by the issuer in this state or applicable marketing or
25 service area, as prescribed in rules adopted by the
26 department, in the individual market in the period involved.
27 To the greatest extent possible, such rules must be consistent
28 with regulations adopted by the United States Department of
29 Health and Human Services.

1 (5)(a) In the case of a health insurance issuer that
2 offers individual health insurance coverage through a network
3 plan, the issuer may:

4 1. Limit the individuals who may be enrolled under
5 such coverage to those who live, reside, or work within the
6 service area for such network plan; and

7 2. Within the service area of such plan, deny such
8 coverage to such individuals if the issuer has demonstrated to
9 the department that:

10 a. It will not have the capacity to deliver services
11 adequately to additional individual enrollees because of its
12 obligations to existing group contract holders and enrollees
13 and individual enrollees; and

14 b. It is applying this paragraph uniformly to
15 individuals without regard to any health-status-related factor
16 of such individuals and without regard to whether the
17 individuals are eligible individuals.

18 (b) An issuer, upon denying individual health
19 insurance coverage in any service area in accordance with
20 subparagraph (a)2., may not offer coverage in the individual
21 market within such service area for a period of 180 days after
22 such coverage is denied.

23 (6)(a) A health insurance issuer may deny individual
24 health insurance coverage to an eligible individual if the
25 issuer has demonstrated to the department that:

26 1. It does not have the financial reserves necessary
27 to underwrite additional coverage; and

28 2. It is applying this paragraph uniformly to all
29 individuals in the individual market in this state consistent
30 with the laws of this state and without regard to any
31

1 health-status-related factor of such individuals and without
2 regard to whether the individuals are eligible individuals.

3 (b) An issuer, upon denying individual health
4 insurance coverage in any service area in accordance with
5 paragraph (a), may not offer such coverage in the individual
6 market within such service area for a period of 180 days after
7 the date such coverage is denied or until the issuer has
8 demonstrated to the department that the issuer has sufficient
9 financial reserves to underwrite additional coverage,
10 whichever occurs later.

11 (7)(a) Subsection (1) does not require that a health
12 insurance issuer that offers health insurance coverage only in
13 connection with group health plans or through one or more bona
14 fide associations, as defined in s. 627.6571(5), or both,
15 offer such health insurance coverage in the individual market.

16 (b) A health insurance issuer that offers health
17 insurance coverage in connection with group health plans is
18 not deemed to be a health insurance issuer offering individual
19 health insurance coverage solely because such issuer offers a
20 conversion policy.

21 (8) This section does not:

22 (a) Restrict the amount of the premium rates that an
23 issuer may charge an individual for individual health
24 insurance coverage; or

25 (b) Prevent a health insurance issuer that offers
26 individual health insurance coverage from establishing premium
27 discounts or rebates or modifying otherwise applicable
28 copayments or deductibles in return for adherence to programs
29 of health promotion and disease prevention.

30 (9) Each health insurance issuer that offers
31 individual health insurance coverage to an eligible individual

1 shall elect to become a risk-assuming carrier or a reinsuring
2 carrier, as provided by s. 627.6475.

3 (10) This section applies to individual health
4 insurance coverage offered on or after January 1, 1998. An
5 individual who would have been eligible for coverage on July
6 1, 1997, shall be eligible for coverage on January 1, 1998,
7 and shall remain eligible for the same period of time after
8 January 1, 1998, that the individual would have remained
9 eligible for coverage after July 1, 1997.

10 Section 6. Section 627.64871, Florida Statutes, is
11 created to read:

12 627.64871 Certification of coverage.--

13 (1) Section 627.6561(8), applies to health insurance
14 coverage offered by an insurer in the individual market in the
15 same manner as it applies to health insurance coverage offered
16 by an insurer in connection with a group health plan in the
17 small-group market or large-group market.

18 (2) This section does not apply to any health
19 insurance coverage in relation to its provision of excepted
20 benefits described in s. 627.6561(5)(b).

21 (3) This section does not apply to any health
22 insurance coverage in relation to its provision of excepted
23 benefits described in s. 627.6561(5)(c), (d), or (e), if the
24 benefits are provided under a separate policy, certificate, or
25 contract of insurance.

26 (4) This section applies to health insurance coverage
27 offered, sold, issued, renewed, or in effect on or after July
28 1, 1997.

29 Section 7. Section 627.6489, Florida Statutes, is
30 created to read:

31 627.6489 Disease Management Program.--

1 (1) The association may contract with insurers to
2 provide disease management services for insurers that elect to
3 participate in the association disease management program.

4 (2) An insurer that elects to contract for such
5 services shall provide the association with all medical
6 records and claims information necessary for the association
7 to effectively manage the services.

8 (3) Monies collected by the association for providing
9 disease management services shall be used by the association
10 to pay administrative expenses associated with the disease
11 management program and to reduce any deficits incurred by the
12 association. No funds received at any time by the association
13 as a result of assessments against insurers may be used in
14 connection with the disease management program. No costs
15 related to the disease management program provided to an
16 insurer shall be assessed against any other insurer.

17 Section 8. Section 627.6512, Florida Statutes, is
18 created to read:

19 627.6512 Exemption of certain group health insurance
20 policies.--Sections 627.6561, 627.65615, 627.65625, and
21 627.6571, do not apply to:

22 (1) Any group insurance policy in relation to its
23 provision of excepted benefits described in s. 627.6561(5)(b).

24 (2) Any group health insurance policy in relation to
25 its provision of excepted benefits described in s.
26 627.6561(5)(c), if the benefits:

27 (a) Are provided under a separate policy, certificate,
28 or contract of insurance; or

29 (b) Are otherwise not an integral part of the policy.
30
31

1 (3) Any group health insurance policy in relation to
2 its provision of excepted benefits described in s.
3 627.6561(5)(d), if all of the following conditions are met:

4 (a) The benefits are provided under a separate policy,
5 certificate, or contract of insurance;

6 (b) There is no coordination between the provision of
7 such benefits and any exclusion of benefits under any group
8 policy maintained by the same policyholder; and

9 (c) Such benefits are paid with respect to an event
10 without regard to whether benefits are provided with respect
11 to such an event under any group health policy maintained by
12 the same policyholder.

13 (4) Any group health policy in relation to its
14 provision of excepted benefits described in s. 627.6561(5)(e),
15 if the benefits are provided under a separate policy,
16 certificate, or contract of insurance.

17 Section 9. Section 627.6561, Florida Statutes, is
18 amended to read:

19 (Substantial rewording of section. See
20 s. 627.6561, F.S., for present text.)
21 627.6561 Preexisting conditions.--

22 (1) As used in this section, the term:

23 (a) "Enrollment date" means, with respect to an
24 individual covered under a group health policy, the date of
25 enrollment of the individual in the plan or coverage or, if
26 earlier, the first day of the waiting period of such
27 enrollment.

28 (b) "Late enrollee" means, with respect to coverage
29 under a group health policy, a participant or beneficiary who
30 enrolls under the policy other than during:

31

1 1. The first period in which the individual is
2 eligible to enroll under the policy.

3 2. A special enrollment period, as provided under s.
4 627.65615.

5 (c) "Waiting period" means, with respect to a group
6 health policy and an individual who is a potential participant
7 or beneficiary of the policy, the period that must pass with
8 respect to the individual before the individual is eligible to
9 be covered for benefits under the terms of the policy.

10 (2) Subject to the exceptions specified in subsection
11 (4), an insurer that offers group health insurance coverage
12 may, with respect to a participant or beneficiary, impose a
13 preexisting condition exclusion only if:

14 (a) Such exclusion relates to a physical or mental
15 condition, regardless of the cause of the condition, for which
16 medical advice, diagnosis, care, or treatment was recommended
17 or received within the 6-month period ending on the enrollment
18 date;

19 (b) Such exclusion extends for a period of not more
20 than 12 months, or 18 months in the case of a late enrollee,
21 after the enrollment date; and

22 (c) The period of any such preexisting condition
23 exclusion is reduced by the aggregate of the periods of
24 creditable coverage, as defined in subsection (5), applicable
25 to the participant or beneficiary as of the enrollment date.

26 (3) Genetic information may not be treated as a
27 condition described in paragraph (2)(a) in the absence of a
28 diagnosis of the condition related to such information.

29 (4)(a) Subject to paragraph (b), an insurer that
30 offers group health insurance coverage, may not impose any
31 preexisting condition exclusion in the case of:

1 1. An individual who, as of the last day of the 30-day
2 period beginning with the date of birth, is covered under
3 creditable coverage.

4 2. A child who is adopted or placed for adoption
5 before attaining 18 years of age and who, as of the last day
6 of the 30-day period beginning on the date of the adoption or
7 placement for adoption, is covered under creditable coverage.
8 This provision does not apply to coverage before the date of
9 such adoption or placement for adoption.

10 3. Pregnancy.

11 (b) Subparagraphs (a)1. and 2. do not apply to an
12 individual after the end of the first 63-day period during all
13 of which the individual was not covered under any creditable
14 coverage.

15 (5)(a) The term, "creditable coverage," means, with
16 respect to an individual, coverage of the individual under any
17 of the following:

18 1. A group health plan, as defined in s. 2791 of the
19 Public Health Service Act.

20 2. Health insurance coverage consisting of medical
21 care, provided directly, through insurance or reimbursement,
22 or otherwise and including terms and services paid for as
23 medical care, under any hospital or medical service policy or
24 certificate, hospital or medical service plan contract, or
25 health maintenance contract offered by a health insurance
26 issuer.

27 3. Medicare, part A or part B of Title XVIII of the
28 Social Security Act, as amended.

29 4. Medicaid, Title XIX of the Social Security Act, as
30 amended, other than children eligible solely for the federal
31 program for the distribution of pediatric vaccines.

- 1 5. Chapter 55 of Title 10, United States Code.
- 2 6. A medical care program of the Indian Health Service
3 or of a tribal organization.
- 4 7. The Florida Comprehensive Health Association or
5 another state health benefit risk pool.
- 6 8. A health plan offered under chapter 89 of Title 5,
7 United States Code.
- 8 9. A public health plan as defined by rules adopted by
9 the department. To the greatest extent possible, such rules
10 must be consistent with regulations adopted by the United
11 States Department of Health and Human Services.
- 12 10. A health benefit plan under s. 5(e) of the Peace
13 Corps Act (22 United States Code, 2504(e)).
- 14 (b) Creditable coverage does not include coverage that
15 consists solely of one or more or any combination thereof of
16 the following excepted benefits:
- 17 1. Coverage only for accident, or disability income
18 insurance, or any combination thereof.
- 19 2. Coverage issued as a supplement to liability
20 insurance.
- 21 3. Liability insurance, including general liability
22 insurance and automobile liability insurance.
- 23 4. Workers' compensation or similar insurance.
- 24 5. Automobile medical payment insurance.
- 25 6. Credit-only insurance.
- 26 7. Coverage for onsite medical clinics, including
27 prepaid health clinics under part II of chapter 641.
- 28 8. Other similar insurance coverage, specified in
29 rules adopted by the department, under which benefits for
30 medical care are secondary or incidental to other insurance
31 benefits. To the extent possible, such rules must be

1 consistent with regulations adopted by the United States
2 Department of Health and Human Services.

3 (c) The following benefits do not constitute
4 creditable coverage, if offered separately:

5 1. Limited scope dental or vision benefits.

6 2. Benefits for long-term care, nursing home care,
7 home health care, community-based care, or any combination
8 thereof.

9 3. Such other similar, limited benefits as are
10 specified in rules adopted by the department.

11 (d) The following benefits do not constitute
12 creditable coverage if offered as independent, noncoordinated
13 benefits:

14 1. Coverage only for a specified disease or illness.

15 2. Hospital indemnity or other fixed indemnity
16 insurance.

17 (e) Benefits provided through a Medicare supplemental
18 health insurance, as defined under s. 1882(g)(1) of the Social
19 Security Act, coverage supplemental to the coverage provided
20 under chapter 55 of Title 10, United States Code, and similar
21 supplemental coverage provided to coverage under a group
22 health plan are not considered creditable coverage if offered
23 as a separate insurance policy.

24 (6)(a) A period of creditable coverage may not be
25 counted, with respect to enrollment of an individual under a
26 group health plan, if, after such period and before the
27 enrollment date, there was a 63-day period during all of which
28 the individual was not covered under any creditable coverage.

29 (b) Any period during which an individual is in a
30 waiting period for any coverage under a group health plan or
31 for group health insurance coverage may not be taken into

1 account in determining the 63-day period under paragraph (a)
2 or paragraph (4)(b).

3 (7)(a) Except as otherwise provided under paragraph
4 (b), an insurer shall count a period of creditable coverage
5 without regard to the specific benefits covered under the
6 period.

7 (b) An insurer may elect to count, as creditable
8 coverage, coverage of benefits within each of several classes
9 or categories of benefits specified in rules adopted by the
10 department rather than as provided under paragraph (a). To the
11 extent possible, such rules must be consistent with
12 regulations adopted by the United States Department of Health
13 and Human Services. Such election shall be made on a uniform
14 basis for all participants and beneficiaries. Under such
15 election, an insurer shall count a period of creditable
16 coverage with respect to any class or category of benefits if
17 any level of benefits is covered within such class or
18 category.

19 (c) In the case of an election with respect to an
20 insurer under paragraph (b), the insurer shall:

21 1. Prominently state in 10-point type or larger in any
22 disclosure statements concerning the policy, and state to each
23 certificateholder at the time of enrollment under the policy,
24 that the insurer has made such election; and

25 2. Include in such statements a description of the
26 effect of this election.

27 (8)(a) Periods of creditable coverage with respect to
28 an individual shall be established through presentation of
29 certifications described in this subsection or in such other
30 manner as is specified in rules adopted by the department. To
31 the extent possible, such rules must be consistent with

1 regulations adopted by the United States Department of Health
2 and Human Services.

3 (b) An insurer that offers group health insurance
4 coverage shall provide the certification described in
5 paragraph (a):

6 1. At the time an individual ceases to be covered
7 under the plan or otherwise becomes covered under a COBRA
8 continuation provision or continuation pursuant to s.
9 627.6692.

10 2. In the case of an individual becoming covered under
11 a COBRA continuation provision or pursuant to s. 627.6692, at
12 the time the individual ceases to be covered under such a
13 provision.

14 3. Upon the request on behalf of an individual made
15 not later than 24 months after the date of cessation of the
16 coverage described in this paragraph.

17
18 The certification under subparagraph 1. may be provided, to
19 the extent practicable, at a time consistent with notices
20 required under any applicable COBRA continuation provision or
21 continuation pursuant to s. 627.6692.

22 (c) The certification described in this section is a
23 written certification that must include:

24 1. The period of creditable coverage of the individual
25 under the policy and the coverage, if any, under such COBRA
26 continuation provision or continuation pursuant to s.
27 627.6692; and

28 2. The waiting period, if any, imposed with respect to
29 the individual for any coverage under such policy.

30 (d) In the case of an election described in subsection
31 (7) by an insurer, if the insurer enrolls an individual for

1 coverage under the plan and the individual provides a
2 certification of coverage of the individual, as provided in
3 this subsection:

4 1. Upon request of such insurer, the insurer that
5 issued the certification provided by the individual shall
6 promptly disclose to such requesting plan or insurer
7 information on coverage of classes and categories of health
8 benefits available under such insurer's plan or coverage.

9 2. Such insurer may charge the requesting insurer for
10 the reasonable cost of disclosing such information.

11 (e) The department shall adopt rules to prevent an
12 insurer's failure to provide information under this subsection
13 with respect to previous coverage of an individual from
14 adversely affecting any subsequent coverage of the individual
15 under another group health plan or health insurance coverage.
16 To the greatest extent possible, such rules must be consistent
17 with regulations adopted by the United States Department of
18 Health and Human Services.

19 (9)(a) Except as provided in paragraph (b), no period
20 before July 1, 1996, shall be taken into account in
21 determining creditable coverage.

22 (b) The department shall adopt rules that provide a
23 process whereby individuals who need to establish creditable
24 coverage for periods before July 1, 1996, and who would have
25 such coverage credited but for paragraph (a), may be given
26 credit for creditable coverage for such periods through the
27 presentation of documents or other means. To the greatest
28 extent possible, such rules must be consistent with
29 regulations adopted by the United States Department of Health
30 and Human Services.

31

1 (10) Except as otherwise provided in this subsection,
2 paragraph (8)(b) applies to events that occur on or after July
3 1, 1996.

4 (a) In no case is a certification required to be
5 provided under paragraph (8)(b) prior to June 1, 1997.

6 (b) In the case of an event that occurs on or after
7 July 1, 1996, and before October 1, 1996, a certification is
8 not required to be provided under paragraph (8)(b), unless an
9 individual, with respect to whom the certification is required
10 to be made, requests such certification in writing.

11 (11) In the case of an individual who seeks to
12 establish creditable coverage for any period for which
13 certification is not required because it relates to an event
14 that occurred before July 1, 1996:

15 (a) The individual may present evidence of other
16 creditable coverage in order to establish the period of
17 creditable coverage.

18 (b) An insurer is not subject to any penalty or
19 enforcement action with respect to the insurer's crediting, or
20 not crediting, such coverage if the insurer has sought to
21 comply in good faith with applicable provisions of this
22 section.

23 (12) For purposes of subsection (9), any plan
24 amendment made pursuant to a collective bargaining agreement
25 relating to the plan which amends the plan solely to conform
26 to any requirement of this section may not be treated as a
27 termination of such collective bargaining agreement.

28 (13) This section does not apply to any health
29 insurance coverage in relation to its provision of excepted
30 benefits described in paragraph (5)(b).

31

1 (14) This section does not apply to any health
2 insurance coverage in relation to its provision of excepted
3 benefits described in paragraphs (5)(c), (d), or (e), if the
4 benefits are provided under a separate policy, certificate, or
5 contract of insurance.

6 (15) This section applies to health insurance coverage
7 offered, sold, issued, renewed, or in effect on or after July
8 1, 1997.

9 Section 10. Section 627.65615, Florida Statutes, is
10 created to read:

11 627.65615 Special enrollment periods.--

12 (1) An insurer that issues a group health insurance
13 policy shall permit an employee who is eligible, but not
14 enrolled, for coverage under the terms of the policy, or a
15 dependent of such an employee if the dependent is eligible but
16 not enrolled for coverage under such terms, to enroll for
17 coverage under the terms of the policy if each of the
18 following conditions is met:

19 (a) The employee or dependent was covered under a
20 group health plan or had health insurance coverage at the time
21 coverage was previously offered to the employee or dependent.
22 For the purpose of this section, the terms "group health plan"
23 and "health insurance coverage" have the same meaning ascribed
24 in s. 2791 of the Public Health Service Act.

25 (b) The employee stated in writing at such time that
26 coverage under a group health plan or health insurance
27 coverage was the reason for declining enrollment, but only if
28 the plan sponsor or insurer, if applicable, required such a
29 statement at such time and provided the employee with notice
30 of such requirement and the consequences of such requirement
31 at such time.

1 (c) The employee's or dependent's coverage described
2 in paragraph (a):

3 1. Was under a COBRA continuation provision or
4 continuation pursuant to s. 627.6692, and the coverage under
5 such provision was exhausted; or

6 2. Was not under such a provision and the coverage was
7 terminated as a result of loss of eligibility for the
8 coverage, including legal separation, divorce, death,
9 termination of employment, or reduction in the number of hours
10 of employment, or the coverage was terminated as a result of
11 the termination of employer contributions toward such
12 coverage.

13 (d) Under the terms of the plan, the employee requests
14 such enrollment not later than 30 days after the date of
15 exhaustion of coverage described in subparagraph (c)1., or
16 termination or employer contribution described in subparagraph
17 (c)2.

18 (2) For dependent beneficiaries, if:

19 (a) A group health insurance policy makes coverage
20 available with respect to a dependent of an individual;

21 (b) The individual is a participant under the policy,
22 or has met any waiting period applicable to becoming a
23 participant under the policy, and is eligible to be enrolled
24 under the policy but for a failure to enroll during a previous
25 enrollment period; and

26 (c) A person becomes such a dependent of the
27 individual through marriage, birth, or adoption or placement
28 for adoption,

29
30 the insurer shall provide for a dependent special enrollment
31 period described in subsection (3) during which the person,

1 or, if not otherwise enrolled, the individual, may be enrolled
2 under the policy as a dependent of the individual, and in the
3 case of the birth or adoption of a child, the spouse of the
4 individual may be enrolled as a dependent of the individual if
5 such spouse is otherwise eligible for coverage.

6 (3) A dependent special enrollment period under
7 subsection (2) shall be a period of not less than 30 days and
8 shall begin on the later of:

9 (a) The date that dependent coverage is made
10 available; or

11 (b) The date of the marriage, birth, or adoption or
12 placement for adoption described in subsection (2)(c).

13 (4) If an individual seeks to enroll a dependent
14 during the first 30 days of such a dependent special
15 enrollment period, the coverage of the dependent shall become
16 effective:

17 (a) In the case of marriage, not later than the first
18 day of the first month beginning after the date the completed
19 request for enrollment is received.

20 (b) In the case of a dependent's birth, as of the date
21 of such birth.

22 (c) In the case of dependent's adoption or placement
23 for adoption, the date of such adoption or placement for
24 adoption.

25 Section 11. Section 627.65625, Florida Statutes, is
26 created to read:

27 627.65625 Prohibiting discrimination against
28 individual participants and beneficiaries based on health
29 status.--

30 (1) Subject to subsection (2), an insurer that offers
31 a group health insurance policy may not establish rules for

1 eligibility, including continued eligibility, of an individual
2 to enroll under the terms of the policy based on any of the
3 following health-status-related factors in relation to the
4 individual or a dependent of the individual:
5 (a) Health status.
6 (b) Medical condition, including physical and mental
7 illnesses.
8 (c) Claims experience.
9 (d) Receipt of health care.
10 (e) Medical history.
11 (f) Genetic information.
12 (g) Evidence of insurability, including conditions
13 arising out of acts of domestic violence.
14 (h) Disability.
15 (2) Subsection (1) does not:
16 (a) Require an insurer to provide particular benefits
17 other than those provided under the terms of such plan or
18 coverage.
19 (b) Prevent such a plan or coverage from establishing
20 limitations or restrictions on the amount, level, extent, or
21 nature of the benefits or coverage for similarly situated
22 individuals enrolled in the plan or coverage.
23 (3) For purposes of subsection (1), rules for
24 eligibility to enroll under a policy include rules for
25 defining any applicable waiting periods of enrollment.
26 (4)(a) An insurer that offers health insurance
27 coverage may not require any individual, as a condition of
28 enrollment or continued enrollment under the policy, to pay a
29 premium or contribution that is greater than such premium or
30 contribution for a similarly situated individual enrolled
31 under the policy on the basis of any health-status-related

1 factor in relation to the individual or to an individual
2 enrolled under the policy as a dependent of the individual.

3 (b) This subsection does not:

4 1. Restrict the amount that an employer may be charged
5 for coverage under a group health insurance policy; or

6 2. Prevent an insurer that offers group health
7 insurance coverage from establishing premium discounts or
8 rebates or modifying otherwise applicable copayments or
9 deductibles in return for adherence to programs of health
10 promotion and disease prevention.

11 Section 12. Section 627.6571, Florida Statutes, is
12 created to read:

13 627.6571 Guaranteed renewability of coverage.--

14 (1) Except as otherwise provided in this section, an
15 insurer that issues a group health insurance policy must renew
16 or continue in force such coverage at the option of the
17 policyholder.

18 (2) An insurer may nonrenew or discontinue a group
19 health insurance policy based only on one or more of the
20 following conditions:

21 (a) The policyholder has failed to pay premiums or
22 contributions in accordance with the terms of the policy or
23 the insurer has not received timely premium payments.

24 (b) The policyholder has performed an act or practice
25 that constitutes fraud or made an intentional
26 misrepresentation of material fact under the terms of the
27 policy.

28 (c) The policyholder has failed to comply with a
29 material provision of the plan which relates to rules for
30 employer contributions or group participation.

31

1 (d) The insurer is ceasing to offer a particular type
2 of coverage in a market in accordance with subsection (3) and
3 applicable state law.

4 (e) In the case of an insurer that offers health
5 insurance coverage through a network plan, there is no longer
6 any enrollee in connection with such plan who lives, resides,
7 or works in the service area of the insurer or in the area in
8 which the insurer is authorized to do business and, in the
9 case of the small-group market, the insurer would deny
10 enrollment with respect to such plan under s. 627.6699(5)(i).

11 (f) In the case of health insurance coverage that is
12 made available only through one or more bona fide associations
13 as defined in subsection (5), the membership of an employer in
14 the association, on the basis of which the coverage is
15 provided, ceases, but only if such coverage is terminated
16 under this paragraph uniformly without regard to any
17 health-status-related factor that relates to any covered
18 individuals.

19 (3)(a) An insurer may discontinue offering a
20 particular policy form of group health insurance coverage
21 offered in the small-group market or large-group market only
22 if:

23 1. The insurer provides notice to each policyholder
24 provided coverage of this form in such market, and to
25 participants and beneficiaries covered under such coverage, of
26 such discontinuation at least 90 days prior to the date of the
27 discontinuation of such coverage;

28 2. The insurer offers to each policyholder provided
29 coverage of this form in such market the option to purchase
30 all, or in the case of the large-group market, any other
31

1 health insurance coverage currently being offered by the
2 insurer in such market; and
3 3. In exercising the option to discontinue coverage of
4 this form and in offering the option of coverage under
5 subparagraph 2., the insurer acts uniformly without regard to
6 the claims experience of those policyholders or any
7 health-status-related factor that relates to any participants
8 or beneficiaries covered or new participants or beneficiaries
9 who may become eligible for such coverage.
10 (b)1. In any case in which an insurer elects to
11 discontinue offering all health insurance coverage in the
12 small-group market or the large-group market, or both, in this
13 state, health insurance coverage may be discontinued by the
14 insurer only if:
15 a. The insurer provides notice to the department and
16 to each policyholder, and participants and beneficiaries
17 covered under such coverage, of such discontinuation at least
18 180 days prior to the date of the discontinuation of such
19 coverage; and
20 b. All health insurance issued or delivered for
21 issuance in this state in such markets is discontinued and
22 coverage under such health insurance coverage in such market
23 is not renewed.
24 2. In the case of a discontinuation under subparagraph
25 1. in a market, the insurer may not provide for the issuance
26 of any health insurance coverage in the market in this state
27 during the 5-year period beginning on the date of the
28 discontinuation of the last insurance coverage not renewed.
29 (c) A mailing to one household constitutes a mailing
30 to all covered persons residing in that household. A separate
31 mailing is required for each separate household.

1 (4) At the time of coverage renewal, an insurer may
2 modify the health insurance coverage for a product offered:
3 (a) In the large-group market; or
4 (b) In the small-group market if, for coverage that is
5 available in such market other than only through one or more
6 bona fide associations as defined in subsection (5), such
7 modification is consistent with s. 627.6699 and effective on a
8 uniform basis among group health plans with that product.
9 (5) As used in this section, the term "bona fide
10 association" means an association that:
11 (a) Has been actively in existence for at least 5
12 years;
13 (b) Has been formed and maintained in good faith for
14 purposes other than obtaining insurance;
15 (c) Does not condition membership in the association
16 on any health-status-related factor that relates to an
17 individual, including an employee of an employer or a
18 dependent of an employee;
19 (d) Makes health insurance coverage offered through
20 the association available to all members regardless of any
21 health-status-related factor that relates to such members or
22 individuals eligible for coverage through a member; and
23 (e) Does not make health insurance coverage offered
24 through the association available other than in connection
25 with a member of the association.
26 (6) In applying this section in the case of health
27 insurance coverage that is made available by an insurer in the
28 small-group market or large-group market to employers only
29 through one or more associations, a reference to
30 "policyholder" is deemed, with respect to coverage provided to
31

1 an employer member of the association, to include a reference
2 to such employer.

3 Section 13. Section 627.6574, Florida Statutes, 1996
4 Supplement, is amended to read:

5 627.6574 Maternity care.--

6 (1) Any group, blanket, or franchise policy of health
7 insurance that provides coverage for maternity care must ~~shall~~
8 also cover the services of certified nurse-midwives and
9 midwives licensed pursuant to chapter 467, and the services of
10 birth centers licensed under ss. 383.30-383.335.

11 (2) Any group, blanket, or franchise policy of health
12 insurance that provides maternity and newborn coverage may not
13 limit coverage for the length of a maternity and newborn stay
14 in a hospital or for followup care outside of a hospital to
15 any time period that is less than that determined to be
16 medically necessary, in accordance with prevailing medical
17 standards and consistent with ~~proposed 1996~~ guidelines for
18 perinatal care of the American Academy of Pediatrics or the
19 American College of Obstetricians and Gynecologists ~~as~~
20 ~~proposed on May 1, 1996~~, by the treating obstetrical care
21 provider or the pediatric care provider.

22 (3) ~~Nothing in~~ This section does not affect ~~affects~~
23 any agreement between an insurer and a hospital or other
24 health care provider with respect to reimbursement for health
25 care services provided, rate negotiations with providers, or
26 capitation of providers, and this section does not prohibit ~~or~~
27 ~~prohibits~~ appropriate utilization review or case management by
28 an insurer.

29 (4) Any group, blanket, or franchise policy of health
30 insurance that provides coverage, benefits, or services for
31 maternity or newborn care must provide coverage for

1 postdelivery care for a mother and her newborn infant. The
2 postdelivery care must include a postpartum assessment and
3 newborn assessment and may be provided at the hospital, at the
4 attending physician's office, at an outpatient maternity
5 center, or in the home by a qualified licensed health care
6 professional trained in mother and baby care. The services
7 must include physical assessment of the newborn and mother,
8 and the performance of any medically necessary clinical tests
9 and immunizations in keeping with prevailing medical
10 standards.

11 (5) An insurer subject to subsection (1) shall
12 communicate active case questions and concerns regarding
13 postdelivery care directly to the treating physician or
14 hospital in written form, in addition to other forms of
15 communication. Such insurers shall also use a process that
16 ~~which~~ includes a written protocol for utilization review and
17 quality assurance.

18 (6) An insurer subject to subsection (1) may not:

19 (a) Deny to a mother or her newborn infant
20 eligibility, or continued eligibility, to enroll or to renew
21 coverage under the terms of the policy for the purpose of
22 avoiding the requirements of this section.

23 (b) Provide monetary payments or rebates to a mother
24 to encourage the mother to accept less than the minimum
25 protections available under this section.

26 (c) Penalize or otherwise reduce or limit the
27 reimbursement of an attending provider solely because the
28 attending provider provided care to an individual participant
29 or beneficiary in accordance with this section.

30 (d) Provide incentives, monetary or otherwise, to an
31 attending provider solely to induce the provider to provide

1 care to an individual participant or beneficiary in a manner
2 inconsistent with this section.

3 (e) Subject to paragraph (7)(c), restrict benefits for
4 any portion of a period within a hospital length of stay
5 required under subsection (2) in a manner that is less
6 favorable than the benefits provided for any preceding portion
7 of such stay.

8 (7)(a) This section does not require a mother who is a
9 participant or beneficiary to:

10 1. Give birth in a hospital.

11 2. Stay in the hospital for a fixed period of time
12 following the birth of her infant.

13 (b) This section does not apply with respect to any
14 health insurance coverage that does not provide benefits for
15 hospital lengths of stay in connection with childbirth for a
16 mother or her newborn infant.

17 (c) This section does not prevent a policy from
18 imposing deductibles, coinsurance, or other cost-sharing in
19 relation to benefits for hospital lengths of stay in
20 connection with childbirth for a mother or her newborn infant,
21 except that such coinsurance or other cost-sharing for any
22 portion of a period within a hospital length of stay required
23 under subsection (2) may not be greater than such coinsurance
24 or cost-sharing for any preceding portion of such stay.

25 Section 14. Subsection (1), paragraph (a) of
26 subsection (3), and subsection (11) of section 627.6675,
27 Florida Statutes, are amended, to read:

28 627.6675 Conversion on termination of
29 eligibility.--Subject to all of the provisions of this
30 section, a group policy delivered or issued for delivery in
31 this state by an insurer or nonprofit health care services

1 plan that provides, on an expense-incurred basis, hospital,
2 surgical, or major medical expense insurance, or any
3 combination of these coverages, shall provide that an employee
4 or member whose insurance under the group policy has been
5 terminated for any reason, including discontinuance of the
6 group policy in its entirety or with respect to an insured
7 class, and who has been continuously insured under the group
8 policy, and under any group policy providing similar benefits
9 that the terminated group policy replaced, for at least 3
10 months immediately prior to termination, shall be entitled to
11 have issued to him by the insurer a policy or certificate of
12 health insurance, referred to in this section as a "converted
13 policy." An employee or member shall not be entitled to a
14 converted policy if termination of his insurance under the
15 group policy occurred because he failed to pay any required
16 contribution, or because any discontinued group coverage was
17 replaced by similar group coverage within 31 days after
18 discontinuance.

19 (1) TIME LIMIT.--Written application for the converted
20 policy shall be made and the first premium must be paid to the
21 insurer, not later than 63 ~~31~~ days after termination of the
22 group policy.

23 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR
24 GROUP COVERAGE.--

25 (a) The premium for the converted policy shall be
26 determined in accordance with premium rates applicable to the
27 age and class of risk of each person to be covered under the
28 converted policy and to the type and amount of insurance
29 provided. However, the premium for the converted policy may
30 not exceed 200 percent of the standard risk rate as
31 established by the Florida Comprehensive Health Association,

1 adjusted for differences in benefit levels and structure
2 between the converted policy and the policy offered by the
3 Florida Comprehensive Health Association.

4 (11) ALTERNATIVE PLANS.--The insurer shall, in
5 addition to the option required by subsection (10), offer the
6 standard health benefit plan, as established pursuant to s.
7 627.6699(12).The insurer may, at its option, also offer
8 alternative plans for group health conversion in addition to
9 the plans ~~one~~ required by this section.

10 Section 15. (1) The changes made by this act to
11 section 627.6675, Florida Statutes, apply to conversion
12 policies offered, sold, issued, or renewed on or after January
13 1, 1998.

14 (2) An individual who was entitled on July 1, 1997, to
15 a conversion policy under section 627.6675, Florida Statutes,
16 shall be entitled on January 1, 1998, to a conversion policy
17 meeting the requirements of section 627.6675, Florida
18 Statutes, as amended by this act. Such an individual shall
19 remain entitled to a conversion policy for the same period of
20 time after January 1, 1998, as the individual would have
21 remained eligible after July 1, 1997, including the condition
22 that application for coverage be made within 63 days of the
23 termination of the group coverage.

24 Section 16. Subsections (3), (5), and (7), and
25 paragraph (b) of subsection (11) of section 627.6699, Florida
26 Statutes, 1996 Supplement, are amended, and present
27 subsections (14) and (15) of that section are redesignated as
28 subsections (15) and (16), respectively, and a new subsection
29 (14) is added to that section, to read:

30 627.6699 Employee Health Care Access Act.--

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

1 (a) "Actuarial certification" means a written
2 statement, by a member of the American Academy of Actuaries or
3 another person acceptable to the department, that a small
4 employer carrier is in compliance with subsection (6), based
5 upon the person's examination, including a review of the
6 appropriate records and of the actuarial assumptions and
7 methods used by the carrier in establishing premium rates for
8 applicable health benefit plans.

9 (b) "Basic health benefit plan" and "standard health
10 benefit plan" mean low-cost health care plans developed
11 pursuant to subsection (12).

12 (c) "Board" means the board of directors of the
13 program.

14 (d) "Carrier" means a person who provides health
15 benefit plans in this state, including an authorized insurer,
16 a health maintenance organization, a multiple-employer welfare
17 arrangement, or any other person providing a health benefit
18 plan that is subject to insurance regulation in this state.
19 However, the term does not include a multiple-employer welfare
20 arrangement, which multiple-employer welfare arrangement
21 operates solely for the benefit of the members or the members
22 and the employees of such members, and was in existence on
23 January 1, 1992.

24 (e) "Case management program" means the specific
25 supervision and management of the medical care provided or
26 prescribed for a specific individual, which may include the
27 use of health care providers designated by the carrier.

28 (f) "Creditable coverage" has the same meaning
29 ascribed in s. 627.6561.

30
31

1 (g)~~(f)~~ "Dependent" means the spouse or child of an
2 eligible employee, subject to the applicable terms of the
3 health benefit plan covering that employee.

4 (h)~~(g)~~ "Eligible employee" means an employee who works
5 full time, having a normal workweek of 25 or more hours, and
6 who has met any applicable waiting-period requirements or
7 other requirements of this act. The term includes a
8 self-employed individual, a sole proprietor, a partner of a
9 partnership, or an independent contractor, if the sole
10 proprietor, partner, or independent contractor is included as
11 an employee under a health benefit plan of a small employer,
12 but does not include a part-time, temporary, or substitute
13 employee.

14 (i)~~(h)~~ "Established geographic area" means the county
15 or counties, or any portion of a county or counties, within
16 which the carrier provides or arranges for health care
17 services to be available to its insureds, members, or
18 subscribers.

19 (j)~~(i)~~ "Guaranteed-issue basis" means an insurance
20 policy that must be offered to an employer, employee, or
21 dependent of the employee, regardless of health status,
22 preexisting conditions, or claims history.

23 (k)~~(j)~~ "Health benefit plan" means any hospital or
24 medical policy or certificate, hospital or medical service
25 plan contract, or health maintenance organization subscriber
26 contract. The term does not include accident-only, specified
27 disease, individual hospital indemnity, credit, dental-only,
28 vision-only, Medicare supplement, long-term care, or
29 disability income insurance; coverage issued as a supplement
30 to liability insurance; workers' compensation or similar
31 insurance; or automobile medical-payment insurance.

1 (l)~~(k)~~ "Late enrollee" means an eligible employee or
2 dependent as defined under s. 627.6561(1)(b).~~who requests~~
3 ~~enrollment in a health benefit plan of a small employer after~~
4 ~~the initial enrollment period provided under the terms of the~~
5 ~~plan has ended. However, an eligible employee or dependent is~~
6 ~~not considered a late enrollee if the enrollee:~~

7 1. ~~Was covered under another employer health benefit~~
8 ~~plan at the time the individual was eligible to enroll; lost~~
9 ~~coverage under that plan as a result of termination of~~
10 ~~employment, the termination of the other plan's coverage, the~~
11 ~~death of a spouse, or divorce; and requests enrollment within~~
12 ~~30 days after coverage under that plan was terminated;~~

13 2. ~~The individual is employed by an employer that~~
14 ~~offers multiple health benefit plans and the individual elects~~
15 ~~a different plan during an open enrollment period; or~~

16 3. ~~A court has ordered that coverage be provided for a~~
17 ~~spouse or minor child under a covered employee's health~~
18 ~~benefit plan and a request for enrollment is made within 30~~
19 ~~days after issuance of the court order.~~

20 (m)~~(l)~~ "Limited benefit policy or contract" means a
21 policy or contract that provides coverage for each person
22 insured under the policy for a specifically named disease or
23 diseases, a specifically named accident, or a specifically
24 named limited market that fulfills an experimental or
25 reasonable need, such as the small group market.

26 (n)~~(m)~~ "Modified community rating" means a method used
27 to develop carrier premiums which spreads financial risk
28 across a large population and allows adjustments for age,
29 gender, family composition, tobacco usage, and geographic area
30 as determined under paragraph (5)(j)~~(k)~~.

31

1 (o)~~(n)~~ "Participating carrier" means any carrier that
2 issues health benefit plans in this state except a small
3 employer carrier that elects to be a risk-assuming carrier.

4 (p)~~(o)~~ "Plan of operation" means the plan of operation
5 of the program, including articles, bylaws, and operating
6 rules, adopted by the board under subsection (11).

7 ~~(p) "Preexisting condition provision" means a policy~~
8 ~~provision that excludes coverage for charges or expenses~~
9 ~~incurred during a specified period following the insured's~~
10 ~~effective date of coverage, as to:~~

11 ~~1. A condition that, during a specified period~~
12 ~~immediately preceding the effective date of coverage, had~~
13 ~~manifested itself in such a manner as would cause an~~
14 ~~ordinarily prudent person to seek medical advice, diagnosis,~~
15 ~~care, or treatment or for which medical advice, diagnosis,~~
16 ~~care, or treatment was recommended or received as to that~~
17 ~~condition; or~~

18 ~~2. Pregnancy existing on the effective date of~~
19 ~~coverage.~~

20 (q) "Program" means the Florida Small Employer Carrier
21 Reinsurance Program created under subsection (11).

22 ~~(r) "Qualifying previous coverage" and "qualifying~~
23 ~~existing coverage" mean benefits or coverage provided under:~~

24 ~~1. An employer-based health insurance or health~~
25 ~~benefit arrangement that provides benefits similar to or~~
26 ~~exceeding benefits provided under the basic health plan; or~~

27 ~~2. An individual health insurance policy, including~~
28 ~~coverage issued by a health maintenance organization, a~~
29 ~~fraternal benefit society, or a multiple-employer welfare~~
30 ~~arrangement, that provides benefits similar to or exceeding~~
31 ~~the benefits provided under the basic health benefit plan,~~

1 ~~provided that such policy has been in effect for a period of~~
2 ~~at least 1 year.~~

3 (r)~~(s)~~ "Rating period" means the calendar period for
4 which premium rates established by a small employer carrier
5 are assumed to be in effect.

6 (s)~~(t)~~ "Reinsuring carrier" means a small employer
7 carrier that elects to comply with the requirements set forth
8 in subsection (11).

9 (t)~~(u)~~ "Risk-assuming carrier" means a small employer
10 carrier that elects to comply with the requirements set forth
11 in subsection (10).

12 (u)~~(v)~~ "Self-employed individual" means an individual
13 or sole proprietor who derives his or her income from a trade
14 or business carried on by the individual or sole proprietor
15 which results in taxable income as indicated on IRS Form 1040,
16 schedule C or F, and which generated taxable income in one of
17 the 2 previous years.

18 (v)~~(w)~~ "Small employer" means, in connection with a
19 health benefit plan with respect to a calendar year and a plan
20 year, any person, sole proprietor, self-employed individual,
21 independent contractor, firm, corporation, partnership, or
22 association that is actively engaged in business, has its
23 principal place of business in this state, and that, on at
24 least 50 percent of its working days during the preceding
25 calendar quarter, employed an average of at least one but not
26 more than 50 eligible employees on business days during the
27 preceding calendar year, and employed at least one employee on
28 the first day of the plan year, the majority of whom were
29 employed within this state. In determining the number of
30 eligible employees, companies that are affiliated companies,
31 or that are eligible to file a combined tax return for

1 ~~purposes of state taxation, may be considered a single~~
2 ~~employer.~~ For purposes of this section, a sole proprietor, an
3 independent contractor, or a self-employed individual is
4 considered a small employer only if all of the conditions and
5 criteria established in this section are met.

6 (w)~~(x)~~ "Small employer carrier" means a carrier that
7 offers health benefit plans covering eligible employees of one
8 or more small employers.

9 (5) AVAILABILITY OF COVERAGE.--

10 (a) Beginning January 1, 1993, every small employer
11 carrier issuing new health benefit plans to small employers in
12 this state must, as a condition of transacting business in
13 this state, offer to eligible small employers a standard
14 health benefit plan and a basic health benefit plan. Such a
15 small employer carrier shall issue a standard health benefit
16 plan or a basic health benefit plan to every eligible small
17 employer that elects to be covered under such plan, agrees to
18 make the required premium payments under such plan, and to
19 satisfy the other provisions of the plan.

20 (b) In the case of a small employer carrier which does
21 not, on or after January 1, 1993, offer coverage but which
22 does, on or after January 1, 1993, renew or continue coverage
23 in force, such carrier shall be required to provide coverage
24 to newly eligible employees and dependents on the same basis
25 as small employer carriers which are offering coverage on or
26 after January 1, 1993.

27 (c) Every small employer carrier must, as a condition
28 of transacting business in this state:

29 1. Beginning January 1, 1994, offer and issue all
30 small employer health benefit plans on a guaranteed-issue
31 basis to every eligible small employer, with 3 to 50 eligible

1 employees, that elects to be covered under such plan, agrees
2 to make the required premium payments, and satisfies the other
3 provisions of the plan. A rider for additional or increased
4 benefits may be medically underwritten and may only be added
5 to the standard health benefit plan. The increased rate
6 charged for the additional or increased benefit must be rated
7 in accordance with this section.

8 2. Beginning April 15, 1994, offer and issue basic and
9 standard small employer health benefit plans on a
10 guaranteed-issue basis to every eligible small employer, with
11 one or two eligible employees, which elects to be covered
12 under such plan, agrees to make the required premium payments,
13 and satisfies the other provisions of the plan. A rider for
14 additional or increased benefits may be medically underwritten
15 and may only be added to the standard health benefit plan.
16 The increased rate charged for the additional or increased
17 benefit must be rated in accordance with this section.

18 3. Offer to eligible small employers the standard and
19 basic health benefit plans. This subparagraph does not limit
20 a carrier's ability to offer other health benefit plans to
21 small employers if the standard and basic health benefit plans
22 are offered and rejected.

23 (d) A small employer carrier must file with the
24 department, in a format and manner prescribed by the
25 committee, a standard health care plan and a basic health care
26 plan to be used by the carrier.

27 (e) The department at any time may, after providing
28 notice and an opportunity for a hearing, disapprove the
29 continued use by the small employer carrier of the standard or
30 basic health benefit plan on the grounds that such plan does
31 not meet the requirements of this section.

1 (f) Except as provided in paragraph (g), a health
2 benefit plan covering small employers, ~~issued or renewed on or~~
3 ~~after October 1, 1992,~~ must comply with preexisting condition
4 provisions specified in s. 627.6561 or, for health maintenance
5 contracts, in s. 641.31071. ~~the following provisions:~~

6 1. ~~Preexisting condition provisions must not exclude~~
7 ~~coverage for a period beyond 12 months following the~~
8 ~~individual's effective date of coverage; and~~

9 2. ~~Preexisting condition provisions may relate only~~
10 ~~to:~~

11 a. ~~Conditions that, during the 6-month period~~
12 ~~immediately preceding the effective date of coverage, had~~
13 ~~manifested themselves in such a manner as would cause an~~
14 ~~ordinarily prudent person to seek medical advice, diagnosis,~~
15 ~~care, or treatment or for which medical advice, diagnosis,~~
16 ~~care, or treatment was recommended or received; or~~

17 b. ~~A pregnancy existing on the effective date of~~
18 ~~coverage.~~

19 (g) A health benefit plan covering small employers,
20 issued or renewed on or after January 1, 1994, must comply
21 with the following conditions:

22 1. All health benefit plans must be offered and issued
23 on a guaranteed-issue basis, except that benefits purchased
24 through riders as provided in paragraph (c) may be medically
25 underwritten for the group, but may not be individually
26 underwritten as to the employees or the dependents of such
27 employees. Additional or increased benefits may only be
28 offered by riders.

29 2. The provisions of paragraph (f) apply to health
30 benefit plans issued to a small employer who has two ~~three~~ or
31 more eligible employees, and to health benefit plans that are

1 issued to a small employer who has fewer than two ~~three~~
2 eligible employees and that cover an employee who has had
3 creditable ~~qualifying previous~~ coverage continually to a date
4 not more than 63 ~~30~~ days before the effective date of the new
5 coverage.

6 ~~3. With respect to any employee or dependent excluded~~
7 ~~from coverage due to disease or medical condition or whose~~
8 ~~coverage had been restricted for certain diseases or medical~~
9 ~~conditions prior to January 1, 1993, and who has continued to~~
10 ~~be an eligible employee or dependent as of April 1, 1993, an~~
11 ~~open enrollment period shall be provided for a 90-day period~~
12 ~~beginning within 60 days following the effective date of this~~
13 ~~act, during which period any such employee or dependent shall~~
14 ~~be entitled to be included within coverage and/or issued~~
15 ~~coverage without restrictions for certain diseases or medical~~
16 ~~conditions.~~

17 3.4. For health benefit plans that are issued to a
18 small employer who has fewer than two ~~three~~ employees and that
19 cover an employee who has not been continually covered by
20 creditable ~~qualifying previous~~ coverage within 63 ~~30~~ days
21 before the effective date of the new coverage, preexisting
22 condition provisions must not exclude coverage for a period
23 beyond 24 months following the employee's effective date of
24 coverage and may relate only to:

25 a. Conditions that, during the 24-month period
26 immediately preceding the effective date of coverage, had
27 manifested themselves in such a manner as would cause an
28 ordinarily prudent person to seek medical advice, diagnosis,
29 care, or treatment or for which medical advice, diagnosis,
30 care, or treatment was recommended or received; or

31

1 b. A pregnancy existing on the effective date of
2 coverage.

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

5 1. ~~In determining whether a preexisting condition~~
6 ~~provision applies to an eligible employee or dependent, credit~~
7 ~~must be given for the time the person was covered under~~
8 ~~qualifying previous coverage if the previous coverage was~~
9 ~~continuous to a date not more than 30 days prior to the~~
10 ~~effective date of the new coverage, exclusive of any~~
11 ~~applicable waiting period under the plan.~~

12 2. ~~Late enrollees may be excluded from coverage only~~
13 ~~for the greater of 18 months or the period of an 18-month~~
14 ~~preexisting condition exclusion; however, if both a period of~~
15 ~~exclusion from coverage and a preexisting condition exclusion~~
16 ~~are applicable to a late enrollee, the combined period may not~~
17 ~~exceed 18 months after the effective date of coverage. For~~
18 ~~employers who have fewer than two ~~three~~ employees, a late~~
19 ~~enrollee may be excluded from coverage for no longer than 24~~
20 ~~months if he was not covered by creditable ~~qualifying previous~~~~
21 ~~coverage continually to a date not more than 63 ~~30~~ days before~~
22 ~~the effective date of his new coverage.~~

23 ~~2.3.~~ Any requirement used by a small employer carrier
24 in determining whether to provide coverage to a small employer
25 group, including requirements for minimum participation of
26 eligible employees and minimum employer contributions, must be
27 applied uniformly among all small employer groups having the
28 same number of eligible employees applying for coverage or
29 receiving coverage from the small employer carrier. A small
30 employer carrier may vary application of minimum participation
31

1 requirements and minimum employer contribution requirements
2 only by the size of the small employer group.

3 ~~3.4.~~ In applying minimum participation requirements
4 with respect to a small employer, a small employer carrier
5 shall not consider as an eligible employee employees or
6 dependents who have qualifying existing coverage in an
7 employer-based group insurance plan or an ERISA qualified
8 self-insurance plan in determining whether the applicable
9 percentage of participation is met, except a small employer
10 carrier may count eligible employees who have coverage under
11 another health plan that is sponsored by that employer.

12 ~~4.5.~~ A small employer carrier shall not increase any
13 requirement for minimum employee participation or any
14 requirement for minimum employer contribution applicable to a
15 small employer at any time after the small employer has been
16 accepted for coverage, unless the employer size has changed,
17 in which case the small employer carrier may apply the
18 requirements that are applicable to the new group size.

19 ~~5.6.~~ If a small employer carrier offers coverage to a
20 small employer, it must offer coverage to all the small
21 employer's eligible employees and their dependents. A small
22 employer carrier may not offer coverage limited to certain
23 persons in a group or to part of a group, except with respect
24 to late enrollees.

25 ~~6.7.~~ A small employer carrier may not modify any
26 health benefit plan issued to a small employer with respect to
27 a small employer or any eligible employee or dependent through
28 riders, endorsements, or otherwise to restrict or exclude
29 coverage for certain diseases or medical conditions otherwise
30 covered by the health benefit plan.

31

1 ~~7.8.~~ An initial enrollment period of at least 30 days
2 must be provided. An annual 30-day open enrollment period
3 must be offered to each small employer's eligible employees
4 and their dependents. A small employer carrier must provide
5 special enrollment periods as required by s. 627.65615.

6 (i)1. A small employer carrier need not offer coverage
7 or accept applications pursuant to paragraph (a):

8 a. To a small employer if the small employer is not
9 physically located in an established geographic service area
10 of the small employer carrier, provided such geographic
11 service area shall not be less than a county;

12 b. To an employee if the employee does not work or
13 reside within an established geographic service area of the
14 small employer carrier; or

15 c. To a small employer group within an area in which
16 the small employer carrier reasonably anticipates, and
17 demonstrates to the satisfaction of the department, that it
18 cannot, within its network of providers, deliver service
19 adequately to the members of such groups because of
20 obligations to existing group contract holders and enrollees.

21 2. A small employer carrier that cannot offer coverage
22 pursuant to sub-subparagraph 1.c. may not offer coverage in
23 the applicable area to new cases of employer groups having
24 more than 50 eligible employees or small employer groups until
25 the later of 180 days following each such refusal or the date
26 on which the carrier notifies the department that it has
27 regained its ability to deliver services to small employer
28 groups.

29 3.a. A small employer carrier may deny health
30 insurance coverage in the small-group market if the carrier
31 has demonstrated to the department that:

1 (I) It does not have the financial reserves necessary
2 to underwrite additional coverage; and

3 (II) It is applying this sub-subparagraph uniformly to
4 all employers in the small-group market in this state
5 consistent with this section and without regard to the claims
6 experience of those employers and their employees and their
7 dependents or any health-status-related factor that relates to
8 such employees and dependents.

9 b. A small employer carrier, upon denying health
10 insurance coverage in connection with health benefit plans in
11 accordance with sub-subparagraph a., may not offer coverage in
12 connection with group health benefit plans in the small-group
13 market in this state for a period of 180 days after the date
14 such coverage is denied or until the insurer has demonstrated
15 to the department that the insurer has sufficient financial
16 reserves to underwrite additional coverage, whichever is
17 later. The department may provide for the application of this
18 sub-subparagraph on a service-area-specific basis.~~The~~
19 ~~department shall, by rule, require each small employer carrier~~
20 ~~to report, along with its annual statement for calendar year~~
21 ~~1992, its gross annual premiums for health benefit plans~~
22 ~~issued to small employers during calendar year 1992, including~~
23 ~~both new and renewal business. No later than May 1, 1993, the~~
24 ~~department shall calculate each carrier's percentage of all~~
25 ~~small employer carrier premiums for calendar year 1992.~~

26 ~~b. During calendar year 1993, a small employer carrier~~
27 ~~may elect to not offer coverage or accept applications~~
28 ~~pursuant to paragraph (a):~~

29 ~~(I) After its gross annual premiums for all small~~
30 ~~employer group health benefit plans written or renewed for~~
31 ~~that year, excluding blocks of business assumed from other~~

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1 ~~carriers, exceeds 25 percent of the total of all small~~
2 ~~employer carrier premiums for calendar year 1992; or~~
3 ~~(II) After its gross annual premiums for small~~
4 ~~employer group health benefit plans written or renewed for~~
5 ~~that year, excluding blocks of business assumed from other~~
6 ~~carriers, exceeds three times that carrier's gross annual~~
7 ~~premiums for small employer group health benefit plans written~~
8 ~~or renewed during calendar year 1992, if its share of small~~
9 ~~employer carrier business for calendar year 1992 calculated~~
10 ~~under sub-subparagraph a. exceeds 2 percent.~~

11 ~~c. The election under sub-subparagraph b. is effective~~
12 ~~upon filing of a notice of election with the department. The~~
13 ~~department may, within 30 days after the filing of the notice,~~
14 ~~disapprove the election if it finds that the carrier does not~~
15 ~~meet the criteria of sub-subparagraph b. If the department~~
16 ~~disapproves the election, the carrier is subject to paragraph~~
17 ~~(a), effective on the date of such disapproval.~~

18 ~~d. An election under sub-subparagraph b. expires on~~
19 ~~December 31, 1993, or upon revocation, whichever occurs~~
20 ~~earlier.~~

21 ~~e. A carrier may file with the department a notice~~
22 ~~revoking its election under sub-subparagraph b. after the~~
23 ~~election has been in effect for at least 3 months. Such~~
24 ~~revocation of an election takes effect on the first day of the~~
25 ~~calendar quarter following the filing of such notice with the~~
26 ~~department and subjects the carrier to all requirements of~~
27 ~~paragraph (a).~~

28 ~~f. While a carrier's election under sub-subparagraph~~
29 ~~b. is in effect, the carrier may not write any further small~~
30 ~~employer group health benefit plans.~~

31

1 ~~g. A carrier may not make an election under~~
2 ~~sub-subparagraph b. more than once.~~

3 4.a. Beginning in 1994, the department shall, by rule,
4 require each small employer carrier to report, on or before
5 March 1 of each year, its gross annual premiums for all health
6 benefit plans issued to small employers during the previous
7 calendar year, and also to report its gross annual premiums
8 for new, but not renewal, standard and basic health benefit
9 plans subject to this section issued during the previous
10 calendar year. No later than May 1 of each year, the
11 department shall calculate each carrier's percentage of all
12 small employer group health premiums for the previous calendar
13 year and shall calculate the aggregate gross annual premiums
14 for new, but not renewal, standard and basic health benefit
15 plans for the previous calendar year.

16 ~~b. Beginning with calendar year 1994, a small employer~~
17 ~~carrier may elect to not offer coverage or accept applications~~
18 ~~pursuant to paragraph (a):~~

19 ~~(I) After its gross annual premiums for new, but not~~
20 ~~renewal, health benefit plans subject to this section for that~~
21 ~~year, excluding blocks of business assumed from other~~
22 ~~carriers, exceeds 25 percent of the aggregate gross annual~~
23 ~~premiums for new, but not renewal, health benefit plans~~
24 ~~subject to this section for the previous calendar year as~~
25 ~~determined under sub-subparagraph a.; or~~

26 ~~(II) After its gross annual premiums for new, but not~~
27 ~~renewal, health benefit plans subject to this section,~~
28 ~~excluding blocks of business assumed from other carriers,~~
29 ~~exceeds three times the carrier's percentage of all small~~
30 ~~employer group premiums for the previous calendar year as~~
31 ~~determined under sub-subparagraph a., multiplied by the~~

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1 ~~aggregate gross annual premiums for new health benefit plans~~
2 ~~for the previous year as determined under sub-subparagraph a.~~
3 ~~A carrier may not exercise this option unless its percentage~~
4 ~~of all small employer group premiums for the previous calendar~~
5 ~~year as determined under sub-subparagraph a. exceeds 2~~
6 ~~percent.~~

7 ~~c. The election under sub-subparagraph b. is effective~~
8 ~~upon filing of a notice of election with the department. The~~
9 ~~department may, within 30 days after the filing of the notice,~~
10 ~~disapprove the election if it finds that the carrier does not~~
11 ~~meet the criteria of sub-subparagraph b. If the department~~
12 ~~disapproves the election, the carrier is subject to paragraph~~
13 ~~(a), effective on the date of such disapproval.~~

14 ~~d. An election under sub-subparagraph b. expires on~~
15 ~~December 31 of the year in which the election was made or upon~~
16 ~~revocation, whichever occurs earlier.~~

17 ~~e. A carrier may file with the department a notice~~
18 ~~revoking its election under sub-subparagraph b. after the~~
19 ~~election has been in effect for at least 3 months. Such~~
20 ~~revocation of an election takes effect on the first day of the~~
21 ~~calendar quarter following the filing of such notice with the~~
22 ~~department and subjects the carrier to all requirements of~~
23 ~~paragraph (a).~~

24 ~~f. While a carrier's election under sub-subparagraph~~
25 ~~b. is in effect, the carrier may not write any further new~~
26 ~~small employer group health benefit plans during the remainder~~
27 ~~of the calendar year.~~

28 ~~g. A carrier may not make an election under~~
29 ~~sub-subparagraph b. more than once in any calendar year.~~

30 ~~(j) A small employer carrier may not offer coverage or~~
31 ~~accept applications pursuant to paragraph (a) if the~~

1 ~~department finds that the acceptance of an application or~~
2 ~~applications would endanger the financial condition of the~~
3 ~~small employer carrier or endanger the interests of the small~~
4 ~~employer carrier's insureds.~~

5 (j)~~(k)~~ The boundaries of geographic areas used by a
6 small employer carrier must coincide with county lines. A
7 carrier may not apply different geographic rating factors to
8 the rates of small employers located within the same county.

9 (7) RENEWABILITY OF COVERAGE.--~~Except as provided in~~
10 ~~paragraph (b),~~A health benefit plan that is subject to this
11 section is renewable for all eligible employees and dependents
12 pursuant to s. 627.6561.~~at the option of the small employer,~~
13 ~~except for any of the following reasons:~~

14 ~~(a) Nonpayment of required premiums;~~

15 ~~(b) Fraud or misrepresentation by the small employer~~
16 ~~or fraud or misrepresentation by the insured individual or~~
17 ~~subscriber or the individual's or subscriber's representative;~~

18 ~~(c) Noncompliance with plan provisions;~~

19 ~~(d) Noncompliance with the carrier's minimum~~
20 ~~participation requirements;~~

21 ~~(e) Noncompliance with the carrier's employer~~
22 ~~contribution requirements;~~

23 ~~(f) The small employer's termination of the business~~
24 ~~in which it was engaged on the effective date of the plan; or~~

25 ~~(g) A determination by the department that the~~
26 ~~continuation of the coverage is not in the best interest of~~
27 ~~the policyholders or certificateholders or will impair the~~
28 ~~carrier's ability to meet its contractual obligations. In~~
29 ~~such instances, the department must assist affected small~~
30 ~~employers in finding replacement coverage.~~

31 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

1 (b)1. The program shall operate subject to the
2 supervision and control of the board.

3 2. Until December 31, 1993, the board shall consist of
4 the commissioner or his designee, who shall serve as chairman,
5 and seven additional members appointed by the commissioner on
6 or before May 1, 1992, as follows:

7 a. One member shall be a representative of the largest
8 health insurer in the state, as determined by market share as
9 of December 31, 1991.

10 b. One member shall be a representative of the largest
11 health maintenance organization in the state, as determined by
12 market share as of December 31, 1991.

13 c. Three members shall be selected from a list of
14 individuals recommended by the Health Insurance Association of
15 America.

16 d. Two members shall be selected from a list of
17 individuals recommended by the Florida Insurance Council.

18
19 The terms of members appointed under this subparagraph expire
20 on December 31, 1993. The appointment of a member under this
21 subparagraph does not preclude the commissioner from
22 appointing the same person to serve as a member under
23 subparagraph 3.

24 3. Beginning January 1, 1994, the board shall consist
25 of the commissioner or his designee, who shall serve as
26 chairman, and eight additional members who are representatives
27 of carriers and are appointed by the commissioner. ~~and serve~~
28 ~~as follows:~~

29 4. Effective upon this act becoming a law, the board
30 shall consist of the commissioner or his or her designee, who
31 shall serve as the chairperson, and 13 additional members who

1 are representatives of carriers and insurance agents and are
2 appointed by the commissioner and serve as follows:
3 a. The commissioner shall include representatives of
4 small employer carriers subject to assessment under this
5 subsection. If two or more carriers elect to be risk-assuming
6 carriers, the membership must include at least two
7 representatives of risk-assuming carriers; if one carrier is
8 risk-assuming, one member must be a representative of such
9 carrier. At least one member must be a carrier who is subject
10 to the assessments, but is not a small employer carrier.
11 Subject to such restrictions, at least five members shall be
12 selected from individuals recommended by small employer
13 carriers pursuant to procedures provided by rule of the
14 department. Three members shall be selected from a list of
15 health insurance carriers that issue individual health
16 insurance policies. At least two of the three members selected
17 must be reinsuring carriers. Two members shall be selected
18 from a list of insurance agents who are actively engaged in
19 the sale of health insurance.
20 b. A member appointed under this subparagraph shall
21 serve a term of 4 years and shall continue in office until the
22 member's successor takes office, except that, in order to
23 provide for staggered terms, the commissioner shall designate
24 two of the initial appointees under this subparagraph to serve
25 terms of 2 years and shall designate three of the initial
26 appointees under this subparagraph to serve terms of 3 years.
27 ~~5.4.~~ The commissioner may remove a member for cause.
28 ~~6.5.~~ Vacancies on the board shall be filled in the
29 same manner as the original appointment for the unexpired
30 portion of the term.
31

1 ~~7.6.~~ The commissioner may require an entity that
2 recommends persons for appointment to submit additional lists
3 of recommended appointees.

4 (14) DISCLOSURE OF INFORMATION.--

5 (a) In connection with the offering of a health
6 benefit plan to a small employer, a small employer carrier
7 shall:

8 1. Make a reasonable disclosure to such employer, as
9 part of its solicitation and sales materials, of the
10 availability of information described in paragraph (b); and

11 2. Upon request of the small employer, provide such
12 information.

13 (b)1. Subject to subparagraph 3., with respect to a
14 small employer carrier that offers a health benefit plan to a
15 small employer, information described in this paragraph is
16 information that concerns:

17 a. The provisions of such coverage concerning an
18 insurer's right to change premium rates and the factors that
19 may affect changes in premium rates;

20 b. The provisions of such coverage that relate to
21 renewability of coverage;

22 c. The provisions of such coverage that relate to any
23 preexisting condition exclusions; and

24 d. The benefits and premiums available under all
25 health insurance coverage for which the employer is qualified.

26 2. Information required under this subsection shall be
27 provided to small employers in a manner determined to be
28 understandable by the average small employer, and shall be
29 sufficient to reasonably inform small employers of their
30 rights and obligations under the health insurance coverage.

31

1 3. An insurer is not required under this subsection to
2 disclose any information that is proprietary or a trade secret
3 under state law.

4 Section 17. Section 627.9404, Florida Statutes, 1996
5 Supplement, is amended to read:

6 627.9404 Definitions.--For the purposes of this part:

7 (1) "Long-term care insurance" means any insurance
8 policy or rider advertised, marketed, offered, or designed to
9 provide coverage on an expense-incurred, indemnity, prepaid,
10 or other basis for one or more necessary or medically
11 necessary diagnostic, preventive, therapeutic, curing,
12 treating, mitigating,rehabilitative, maintenance, or personal
13 care services provided in a setting other than an acute care
14 unit of a hospital. Long-term care insurance shall not
15 include any insurance policy which is offered primarily to
16 provide basic Medicare supplement coverage, basic hospital
17 expense coverage, basic medical-surgical expense coverage,
18 hospital confinement indemnity coverage, major medical expense
19 coverage, disability income protection coverage, accident only
20 coverage, specified disease or specified accident coverage, or
21 limited benefit health coverage.

22 (2) "Applicant" means:

23 (a) In the case of an individual long-term care
24 insurance policy, the person who seeks to contract for
25 benefits.

26 (b) In the case of a group long-term care insurance
27 policy, the proposed certificateholder.

28 (3) "Certificate" means any certificate issued under a
29 group long-term care insurance policy, which policy has been
30 delivered or issued for delivery in this state.

31

1 (4) "Chronically ill" means certified, within the
2 preceding 12-month period, by a licensed health care
3 practitioner as:
4 (a) Being unable to perform, without substantial
5 assistance from another individual, at least two activities of
6 daily living for a period of at least 90 days due to a loss of
7 functional capacity;
8 (b) Having a level of disability similar to the level
9 of disability described in paragraph (a); or
10 (c) Requiring substantial supervision for protection
11 from threats to health and safety due to severe cognitive
12 impairment.
13 ~~(5)~~(4) "Cognitive impairment" means a deficiency in a
14 person's short-term or long-term memory, orientation as to
15 person, place, and time, deductive or abstract reasoning, or
16 judgment as it relates to safety awareness.
17 (6) "Licensed health care practitioner" means any
18 physician, nurse licensed under chapter 464, or
19 psychotherapist licensed under chapter 490 or chapter 491, or
20 any individual who meets any requirements prescribed by rule
21 by the Insurance Commissioner.
22 (7) "Maintenance or personal care services" means any
23 care the primary purpose of which is the provision of needed
24 assistance with any of the disabilities as a result of which
25 the individual is a chronically ill individual, including the
26 protection from threats to health and safety due to severe
27 cognitive impairment.
28 ~~(8)~~(5) "Policy" means any policy, contract, subscriber
29 agreement, rider, or endorsement delivered or issued for
30 delivery in this state by any of the entities specified in s.
31 627.9403.

1 (9) "Qualified long-term care services" means
2 necessary diagnostic, preventive, curing, treating,
3 mitigating, and rehabilitative services, and maintenance or
4 personal care services which are required by a chronically ill
5 individual and are provided pursuant to a plan of care
6 prescribed by a licensed health care practitioner.

7 (10) "Qualified long-term care insurance policy" means
8 an accident and health insurance contract as defined in s.
9 7702B(b) of the Internal Revenue Code.

10 Section 18. Subsection (1) of section 627.9407,
11 Florida Statutes, is amended, and subsection (12) is added to
12 said section, to read:

13 627.9407 Disclosure, advertising, and performance
14 standards for long-term care insurance.--

15 (1) STANDARDS.--The department shall adopt rules that
16 include standards for full and fair disclosure setting forth
17 the manner, content, and required disclosures of the sale of
18 long-term care insurance policies, terms of renewability,
19 initial and subsequent conditions of eligibility,
20 nonduplication of coverage provisions, coverage of dependents,
21 preexisting conditions, termination of insurance, continuation
22 or conversion, probationary periods, limitations, exceptions,
23 reductions, elimination periods, requirements for replacement,
24 recurrent conditions, disclosure of tax consequences, benefit
25 triggers, prohibition against post-claims underwriting,
26 reporting requirements, standards for marketing, and
27 definitions of terms.

28 (12) DISCLOSURE.--A qualified long-term care insurance
29 policy must include a disclosure statement within the policy
30 and within the outline of coverage that the policy is intended
31 to be a qualified long-term contract. A long-term care

1 insurance policy that is not intended to be a qualified
2 long-term care insurance contract must include a disclosure
3 statement within the policy and within the outline of coverage
4 that the policy is not intended to be a qualified long-term
5 care insurance contract. The disclosure shall be prominently
6 displayed and shall read as follows: "This long-term care
7 insurance policy is not intended to be a qualified long-term
8 care insurance contract. You need to be aware that benefits
9 received under this policy may create unintended, adverse
10 income tax consequences to you. You may want to consult with a
11 knowledgeable individual about such potential income tax
12 consequences."

13 Section 19. Subsections (6), (7), (8), (9), and (10)
14 are added to section 627.94071, Florida Statutes, 1996
15 Supplement, to read:

16 627.94071 Minimum standards for home health care
17 benefits.--A long-term care insurance policy, certificate, or
18 rider that contains a home health care benefit must meet or
19 exceed the minimum standards specified in this section. The
20 policy, certificate, or rider may not exclude benefits by any
21 of the following means:

22 (6) Excluding coverage for personal care services
23 provided by a home health aide.

24 (7) Requiring that the provision of home health care
25 services be at a level of certification or licensure greater
26 than that required by the eligible service.

27 (8) Requiring that the insured/claimant have an acute
28 condition before home health care services are covered.

29 (9) Limiting benefits to services provided by
30 Medicare-certified agencies or providers.

31 (10) Excluding coverage for adult day care services.

1 Section 20. Subsection (2) of section 627.94072,
2 Florida Statutes, 1996 Supplement, is amended to read:

3 627.94072 Mandatory offers.--

4 (2) An insurer that offers a long-term care insurance
5 policy, certificate, or rider in this state must offer a
6 nonforfeiture protection provision providing reduced paid-up
7 insurance, ~~cash surrender values which may include return of~~
8 ~~premiums~~, extended term, shortened benefit period, or any
9 other benefits approved by the department if all or part of a
10 premium is not paid. Nonforfeiture benefits and any
11 additional premium for such benefits must be computed in an
12 actuarially sound manner, using a methodology that has been
13 filed with and approved by the department.

14 Section 21. Section 627.94073, Florida Statutes, 1996
15 Supplement, is amended to read:

16 627.94073 Notice of cancellation; grace period.--

17 (1) A long-term care policy shall provide that the
18 insured is entitled to a grace period of not less than 30
19 days, within which payment of any premium after the first may
20 be made. The insurer may require payment of an interest
21 charge not in excess of 8 percent per year for the number of
22 days elapsing before the payment of the premium, during which
23 period the policy shall continue in force. If the policy
24 becomes a claim during the grace period before the overdue
25 premium is paid, the amount of such premium or premiums with
26 interest not in excess of 8 percent per year may be deducted
27 in any settlement under the policy.

28 (2) A long-term care policy may not be canceled for
29 nonpayment of premium unless, after expiration of the grace
30 period in subsection (1), and at least 30 days prior to the
31 effective date of such cancellation, the insurer has mailed a

1 notification of possible lapse in coverage to the policyholder
2 and to a specified secondary addressee if such addressee has
3 been designated in writing by name and address by the
4 policyholder. For policies issued or renewed on or after
5 October 1, 1996, the insurer shall notify the policyholder, at
6 least once every 2 years, of the right to designate a
7 secondary addressee. The applicant has the right to designate
8 at least one person who is to receive the notice of
9 termination, in addition to the insured. Designation shall not
10 constitute acceptance of any liability on the third party for
11 services provided to the insured. The form used for the
12 written designation must provide space clearly designated for
13 listing at least one person. The designation shall include
14 each person's full name and home address. In the case of an
15 applicant who elects not to designate an additional person,
16 the waiver shall state: "Protection against unintended
17 lapse.--I understand that I have the right to designate at
18 least one person other than myself to receive notice of lapse
19 or termination of this long-term care insurance policy for
20 nonpayment of premium. I understand that notice will not be
21 given until 30 days after a premium is due and unpaid. I elect
22 NOT to designate any person to receive such notice." Notice
23 shall be given by first class United States mail, postage
24 prepaid, and notice may not be given until 30 days after a
25 premium is due and unpaid. Notice shall be deemed to have been
26 given as of 5 days after the date of mailing.

27 (3) If a policy is canceled due to nonpayment of
28 premium, the policyholder shall be entitled to have the policy
29 reinstated if, within a period of not less than 5 months ~~150~~
30 ~~days~~ after the date of cancellation, the policyholder or any
31 secondary addressee designated pursuant to subsection (2)

1 demonstrates that the failure to pay the premium when due was
2 unintentional and due to the cognitive impairment or loss of
3 functional capacity of the policyholder. Policy reinstatement
4 shall be subject to payment of overdue premiums. The standard
5 of proof of cognitive impairment or loss of functional
6 capacity shall not be more stringent than the benefit
7 eligibility criteria for cognitive impairment or the loss of
8 functional capacity, if any, contained in the policy and
9 certificate.The insurer may require payment of an interest
10 charge not in excess of 8 percent per year for the number of
11 days elapsing before the payment of the premium, during which
12 period the policy shall continue in force if the demonstration
13 of cognitive impairment is made. If the policy becomes a
14 claim during the 180-day period before the overdue premium is
15 paid, the amount of the premium or premiums with interest not
16 in excess of 8 percent per year may be deducted in any
17 settlement under the policy.

18 (4) When the policyholder or certificateholder pays
19 premium for a long-term care insurance policy or certificate
20 policy through a payroll or pension deduction plan, the
21 requirements in subsection (2) need not be met until 60 days
22 after the policyholder or certificateholder is no longer on
23 such a payment plan. The application or enrollment form for
24 such policies or certificates shall clearly indicate the
25 payment plan selected by the applicant.

26 Section 22. Section 627.94074, Florida Statutes, 1996
27 Supplement, is amended to read:

28 627.94074 Standards for benefit triggers.--

29 (1)(a) A long-term care insurance policy shall
30 condition the payment of benefits on a determination of the
31 insured's ability to perform activities of daily living and on

1 cognitive impairment. Eligibility for the payment of benefits
2 shall not be more restrictive than requiring either a
3 deficiency in the ability to perform not more than three of
4 the activities of daily living or the presence of cognitive
5 impairment; ~~or-~~

6 (b) If a policy is a qualified long-term care
7 insurance policy, the policy shall condition the payment of
8 benefits on a determination of the insured as being
9 chronically ill; having a level of disability similar, as
10 provided by rule of the Insurance Commissioner, to the
11 insured's ability to perform activities of daily living; or
12 being cognitively impaired as described in paragraph (6)(b).
13 Eligibility for the payment of benefits shall not be more
14 restrictive than requiring a deficiency in the ability to
15 perform not more than three of the activities of daily living.

16 (2) Activities of daily living shall include at least:

17 (a) "Bathing," which means washing oneself by sponge
18 bath or in either a tub or shower, including the task of
19 getting into or out of the tub or shower.

20 (b) "Continence," which means the ability to maintain
21 control of bowel and bladder function, or, when unable to
22 maintain control of bowel or bladder function, the ability to
23 perform associated personal hygiene, including caring for
24 catheter or colostomy bag.

25 (c) "Dressing," which means putting on and taking off
26 all items of clothing and any necessary braces, fasteners, or
27 artificial limbs.

28 (d) "Eating," which means feeding oneself by getting
29 food into the body from a receptacle, such as a plate, cup, or
30 table, or by a feeding tube or intravenously.

31

1 (e) "Toileting," which means getting to and from the
2 toilet, getting on and off the toilet, and performing
3 associated personal hygiene.

4 (f) "Transferring," which means moving into or out of
5 a bed, chair, or wheelchair.

6 (3) Insurers may use activities of daily living to
7 trigger covered benefits in addition to those contained in
8 subsection (2) as long as they are defined in the policy.

9 (4) An issuer of qualified long-term care contracts is
10 limited to considering only the activities of daily living
11 listed in subsection (2).

12 (5)~~(4)~~ An insurer may use additional provisions, for a
13 policy described in paragraph (1)(a), for the determination of
14 when benefits are payable under a policy or certificate;
15 however, the provisions shall not restrict and are not in lieu
16 of, the requirements contained in subsections (1) and (2).

17 (6)~~(5)~~ For purposes of this section, the determination
18 of a deficiency due to loss of functional capacity or
19 cognitive impairment shall not be more restrictive than:

20 (a) Requiring the hands-on assistance of another
21 person to perform the prescribed activities of daily living,
22 meaning physical assistance, minimal, moderate, or maximal,
23 without which the individual would not be able to perform the
24 activity of daily living; or

25 (b) ~~if the deficiency is~~ Due to the presence of a
26 cognitive impairment, requiring supervision, including or
27 verbal cueing by another person ~~is needed~~ in order to protect
28 the insured or others.

29 (7)~~(6)~~ Assessment of activities of daily living and
30 cognitive impairment shall be performed by licensed or
31

1 certified professionals, such as physicians, nurses, or social
2 workers.

3 ~~(8)(7)~~ Long-term care insurance policies shall include
4 a clear description of the process for appealing and resolving
5 the benefit determinations.

6 ~~(9)(8)~~ The requirement set forth in this section shall
7 be effective on July 1, 1997, and shall apply as follows:

8 (a) Except as provided in paragraph (b), the
9 provisions of this section apply to a long-term care policy
10 issued in this state on or after July 1, 1997.

11 (b) The provisions of this section do not apply to
12 certificates under a group long-term care insurance policy in
13 force on July 1, 1997.

14 Section 23. Section 641.2018, Florida Statutes, is
15 created to read:

16 641.2018 High-deductible contracts for medical savings
17 accounts.--Notwithstanding the provisions of this part and
18 part III related to the requirement for providing
19 comprehensive coverage, a health maintenance organization may
20 offer a high-deductible contract to employers that establish
21 medical savings accounts, as defined in section 220(d) of the
22 Internal Revenue Code.

23 Section 24. Subsection (18) of section 641.31, Florida
24 Statutes, 1996 Supplement, is amended to read:

25 641.31 Health maintenance contracts.--

26 (18)(a) Health maintenance contracts that ~~which~~
27 provide coverage, benefits, or services for maternity care
28 must ~~shall~~ provide, as an option to the subscriber, the
29 services of nurse-midwives and midwives licensed pursuant to
30 chapter 467, and the services of birth centers licensed

31

1 pursuant to ss. 383.30-383.335, if such services are available
2 within the service area.

3 (b) Any health maintenance contract that ~~which~~
4 provides maternity or newborn coverage may not limit coverage
5 for the length of a maternity or newborn stay in a hospital or
6 for followup care outside of a hospital to any time period
7 that is less than that determined to be medically necessary,
8 in accordance with prevailing medical standards and consistent
9 with ~~proposed 1996~~ guidelines for perinatal care of the
10 American Academy of Pediatrics or the American College of
11 Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by
12 the treating obstetrical care provider or the pediatric care
13 provider.

14 (c) ~~Nothing in~~ This section does not affect ~~affects~~
15 any agreement between a health maintenance organization and a
16 hospital or other health care provider with respect to
17 reimbursement for health care services provided, rate
18 negotiations with providers, or capitation of providers, and
19 this section does not prohibit ~~or prohibits~~ appropriate
20 utilization review or case management by a health maintenance
21 organization.

22 (d) Any health maintenance contract that provides
23 coverage, benefits, or services for maternity or newborn care
24 must provide coverage for postdelivery care for a mother and
25 her newborn infant. The postdelivery care must include a
26 postpartum assessment and newborn assessment and may be
27 provided at the hospital, at the attending physician's office,
28 at an outpatient maternity center, or in the home by a
29 qualified licensed health care professional trained in mother
30 and baby care. The services must include physical assessment
31 of the newborn and mother, and the performance of any

1 medically necessary clinical tests and immunizations in
2 keeping with prevailing medical standards.

3 (e) A health maintenance organization subject to
4 paragraph (b) shall communicate active case questions and
5 concerns regarding postdelivery care directly to the treating
6 physician or hospital in written form, in addition to other
7 forms of communication. Such organization shall also use a
8 process that ~~which~~ includes a written protocol for utilization
9 review and quality assurance.

10 (f) Any health maintenance organization subject to
11 paragraph (b) may not:

12 1. Deny to a mother or her newborn infant eligibility,
13 or continued eligibility, to enroll or to renew coverage under
14 the terms of the contract for the purpose of avoiding the
15 requirements of this section.

16 2. Provide monetary payments or rebates to a mother to
17 encourage the mother to accept less than the minimum
18 protections available under this section.

19 3. Penalize or otherwise reduce or limit the
20 reimbursement of an attending provider solely because the
21 attending provider provided care to an individual participant
22 or beneficiary in accordance with this section.

23 4. Provide incentives, monetary or otherwise, to an
24 attending provider solely to induce the provider to provide
25 care to an individual participant or beneficiary in a manner
26 inconsistent with this section.

27 5. Subject to paragraph (i), restrict benefits for any
28 portion of a period within a hospital length of stay required
29 under paragraph (b) in a manner that is less favorable than
30 the benefits provided for any preceding portion of such stay.
31

1 (g) This subsection does not require a mother who is a
2 participant or beneficiary to:

3 1. Give birth in a hospital.

4 2. Stay in the hospital for a fixed period of time
5 following the birth of her infant.

6 (h) This subsection does not apply with respect to any
7 coverage offered by a health maintenance organization that
8 does not provide benefits for hospital lengths of stay in
9 connection with childbirth for a mother or her newborn infant.

10 (i) This subsection does not prevent a health
11 maintenance organization from imposing deductibles,
12 coinsurance, or other cost-sharing in relation to benefits for
13 hospital lengths of stay in connection with childbirth for a
14 mother or her newborn infant under the contract or under
15 health insurance coverage offered in connection with a group
16 health plan, except that such coinsurance or other
17 cost-sharing for any portion of a period within a hospital
18 length of stay required under paragraph (b) may not be greater
19 than such coinsurance or cost-sharing for any preceding
20 portion of such stay.

21 Section 25. Section 641.3102, Florida Statutes, is
22 amended to read:

23 641.3102 Restrictions upon expulsion or refusal to
24 issue or renew contract.--

25 (1) A health maintenance organization that offers
26 individual health maintenance contracts in this state may not
27 decline to offer coverage to an eligible individual as
28 required in s. 627.6487.

29 (2) A health maintenance organization shall not expel
30 or refuse to renew the coverage of, or refuse to enroll, any
31 individual member of a subscriber group on the basis of the

1 race, color, creed, marital status, sex, or national origin of
2 the subscriber or individual. A health maintenance
3 organization shall not expel or refuse to renew the coverage
4 of any individual member of a subscriber group on the basis of
5 the age, health status, health care needs, or prospective
6 costs of health care services of the subscriber or individual.
7 Nothing in this section shall prohibit a health maintenance
8 organization from requiring that, as a condition of continued
9 eligibility for membership, dependents of a subscriber, upon
10 reaching a specified age, convert to a converted contract or
11 that individuals entitled to have payments for health costs
12 made under Title XVIII of the United States Social Security
13 Act, as amended, be issued a health maintenance contract for
14 Medicare beneficiaries so long as the health maintenance
15 organization is authorized to issue health maintenance
16 contracts for Medicare beneficiaries.

17 Section 26. Section 641.31071, Florida Statutes, is
18 created to read:

19 641.31071 Preexisting conditions.--

20 (1) As used in this section, the term:

21 (a) "Enrollment date" means, with respect to an
22 individual covered under a group health maintenance
23 organization contract, the date of enrollment of the
24 individual in the plan or coverage or, if earlier, the first
25 day of the waiting period of such enrollment.

26 (b) "Late enrollee" means, with respect to coverage
27 under a group health maintenance organization contract, a
28 participant or beneficiary who enrolls under the contract
29 other than during:

30 1. The first period in which the individual is
31 eligible to enroll under the plan.

1 2. A special enrollment period, as provided under s.
2 641.31072.

3 (c) "Waiting period" means, with respect to a group
4 health maintenance organization contract and an individual who
5 is a potential participant or beneficiary under the contract,
6 the period that must pass with respect to the individual
7 before the individual is eligible to be covered for benefits
8 under the terms of the contract.

9 (2) Subject to the exceptions specified in subsection
10 (4), a health maintenance organization that offers group
11 coverage, may, with respect to a participant or beneficiary,
12 impose a preexisting condition exclusion only if:

13 (a) Such exclusion relates to a physical or mental
14 condition, regardless of the cause of the condition, for which
15 medical advice, diagnosis, care, or treatment was recommended
16 or received within the 6-month period ending on the enrollment
17 date;

18 (b) Such exclusion extends for a period of not more
19 than 12 months, or 18 months in the case of a late enrollee,
20 after the enrollment date; and

21 (c) The period of any such preexisting condition
22 exclusion is reduced by the aggregate of the periods of
23 creditable coverage, as defined in subsection (5), applicable
24 to the participant or beneficiary as of the enrollment date.

25 (3) Genetic information shall not be treated as a
26 condition described in paragraph (2)(a) in the absence of a
27 diagnosis of the condition related to such information.

28 (4)(a) Subject to paragraph (b), a health maintenance
29 organization that offers group coverage may not impose any
30 preexisting condition exclusion in the case of:

31

1 1. An individual who, as of the last day of the 30-day
2 period beginning with the date of birth, is covered under
3 creditable coverage.

4 2. A child who is adopted or placed for adoption
5 before attaining 18 years of age and who, as of the last day
6 of the 30-day period beginning on the date of the adoption or
7 placement for adoption, is covered under creditable coverage.
8 This provision shall not apply to coverage before the date of
9 such adoption or placement for adoption.

10 3. Pregnancy.

11 (b) Subparagraphs (a)1. and 2. do not apply to an
12 individual after the end of the first 63-day period during all
13 of which the individual was not covered under any creditable
14 coverage.

15 (5)(a) The term, "creditable coverage," means, with
16 respect to an individual, coverage of the individual under any
17 of the following:

18 1. A group health plan, as defined in s. 2791, of the
19 Public Health Service Act.

20 2. Health insurance coverage consisting of medical
21 care, provided directly, through insurance or reimbursement or
22 otherwise, and including terms and services paid for as
23 medical care, under any hospital or medical service policy or
24 certificate, hospital or medical service plan contract, or
25 health maintenance contract offered by a health insurance
26 issuer.

27 3. Medicare, part A or part B of Title XVIII of the
28 Social Security Act, as amended.

29 4. Medicaid, Title XIX of the Social Security Act, as
30 amended, other than children eligible solely for the federal
31 program for the distribution of pediatric vaccines.

- 1 5. Chapter 55 of Title 10, United States Code.
- 2 6. A medical care program of the Indian Health Service
3 or of a tribal organization.
- 4 7. The Florida Comprehensive Health Association or
5 another state health benefit risk pool.
- 6 8. A health plan offered under chapter 89 of Title 5,
7 United States Code.
- 8 9. A public health plan as defined by rule of the
9 department. To the greatest extent possible, such rules must
10 be consistent with regulations adopted by the United States
11 Department of Health and Human Services.
- 12 10. A health benefit plan under s. 5(e) of the Peace
13 Corps Act (22 United States Code, 2504(e)).
- 14 (b) Creditable coverage does not include coverage that
15 consists solely of one or more or any combination thereof of
16 the following excepted benefits:
- 17 1. Coverage only for accident, or disability income
18 insurance, or any combination thereof.
- 19 2. Coverage issued as a supplement to liability
20 insurance.
- 21 3. Liability insurance, including general liability
22 insurance and automobile liability insurance.
- 23 4. Workers' compensation or similar insurance.
- 24 5. Automobile medical payment insurance.
- 25 6. Credit-only insurance.
- 26 7. Coverage for onsite medical clinics.
- 27 8. Other similar insurance coverage, specified in
28 rules adopted by the department, under which benefits for
29 medical care are secondary or incidental to other insurance
30 benefits. To the greatest extent possible, such rules must be
31

1 consistent with regulations adopted by the United States
2 Department of Health and Human Services.

3 (c) The following benefits do not constitute
4 creditable coverage, if offered separately:

5 1. Limited scope dental or vision benefits.

6 2. Benefits or long-term care, nursing home care, home
7 health care, community-based care, or any combination of
8 these.

9 3. Such other similar, limited benefits as are
10 specified in rules adopted by the department. To the greatest
11 extent possible, such rules must be consistent with
12 regulations adopted by the United States Department of Health
13 and Human Services.

14 (d) The following benefits do not constitute
15 creditable coverage if offered as independent, noncoordinated
16 benefits:

17 1. Coverage only for a specified disease or illness.

18 2. Hospital indemnity or other fixed indemnity
19 insurance.

20 (e) Benefits provided through Medicare supplemental
21 health insurance, as defined under s. 1882(g)(1) of the Social
22 Security Act, coverage supplemental to the coverage provided
23 under chapter 55 of Title 10, United States Code, and similar
24 supplemental coverage provided to coverage under a group
25 health plan are not considered creditable coverage if offered
26 as a separate insurance policy.

27 (6)(a) A period of creditable coverage may not be
28 counted, with respect to enrollment of an individual under a
29 group health maintenance organization contract, if, after such
30 period and before the enrollment date, there was a 63-day
31

1 period during all of which the individual was not covered
2 under any creditable coverage.

3 (b) Any period during which an individual is in a
4 waiting period, or in an affiliation period as defined in
5 subsection (9), for any coverage under a group health
6 maintenance organization contract may not be taken into
7 account in determining the 63-day period under paragraph (a)
8 or paragraph (4)(b).

9 (7)(a) Except as otherwise provided under paragraph
10 (b), a health maintenance organization shall count a period of
11 creditable coverage without regard to the specific benefits
12 covered under the period.

13 (b) A health maintenance organization may elect to
14 count as creditable coverage, coverage of benefits within each
15 of several classes or categories of benefits specified in
16 rules adopted by the department rather than as provided under
17 paragraph (a). Such election shall be made on a uniform basis
18 for all participants and beneficiaries. Under such election, a
19 health maintenance organization shall count a period of
20 creditable coverage with respect to any class or category of
21 benefits if any level of benefits is covered within such class
22 or category.

23 (c) In the case of an election with respect to a
24 health maintenance organization under paragraph (b), the
25 organization shall:

26 1. Prominently state in 10-point type or larger in any
27 disclosure statements concerning the contract, and state to
28 each enrollee at the time of enrollment under the contract,
29 that the organization has made such election; and

30 2. Include in such statements a description of the
31 effect of this election.

1 (8)(a) Periods of creditable coverage with respect to
2 an individual shall be established through presentation of
3 certifications described in this subsection or in such other
4 manner as may be specified in rules adopted by the department.

5 (b) A health maintenance organization that offers
6 group coverage shall provide the certification described in
7 paragraph (a):

8 1. At the time an individual ceases to be covered
9 under the plan or otherwise becomes covered under a COBRA
10 continuation provision or continuation pursuant to s.
11 627.6692.

12 2. In the case of an individual becoming covered under
13 a COBRA continuation provision or pursuant to s. 627.6692, at
14 the time the individual ceases to be covered under such a
15 provision.

16 3. Upon the request on behalf of an individual made
17 not later than 24 months after the date of cessation of the
18 coverage described in this paragraph.

19
20 The certification under subparagraph 1. may be provided, to
21 the extent practicable, at a time consistent with notices
22 required under any applicable COBRA continuation provision or
23 continuation pursuant to s. 627.6692.

24 (c) The certification is a written certification of:

25 1. The period of creditable coverage of the individual
26 under the contract and the coverage, if any, under such COBRA
27 continuation provision or continuation pursuant to s.
28 627.6692; and

29 2. The waiting period, if any, imposed with respect to
30 the individual for any coverage under such contract.

31

1 (d) In the case of an election described in subsection
2 (7) by a health maintenance organization, if the organization
3 enrolls an individual for coverage under the plan and the
4 individual provides a certification of coverage of the
5 individual, as provided by this subsection:
6 1. Upon request of such health maintenance
7 organization, the insurer or health maintenance organization
8 that issued the certification provided by the individual shall
9 promptly disclose to such requesting organization information
10 on coverage of classes and categories of health benefits
11 available under such insurer's or health maintenance
12 organization's plan or coverage.
13 2. Such insurer or health maintenance organization may
14 charge the requesting organization for the reasonable cost of
15 disclosing such information.
16 (e) The department shall adopt rules to prevent an
17 insurer's or health maintenance organization's failure to
18 provide information under this subsection with respect to
19 previous coverage of an individual from adversely affecting
20 any subsequent coverage of the individual under another group
21 health plan or health maintenance organization coverage.
22 (9)(a) A health maintenance organization may provide
23 for an affiliation period with respect to coverage through the
24 organization only if:
25 1. No preexisting condition exclusion is imposed with
26 respect to coverage through the organization;
27 2. The period is applied uniformly without regard to
28 any health-status-related factors; and
29 3. Such period does not exceed 2 months or 3 months in
30 the case of a late enrollee.
31

1 (b) For the purposes of this section, the term
2 "affiliation period" means a period that, under the terms of
3 the coverage offered by the health maintenance organization,
4 must expire before the coverage becomes effective. The
5 organization is not required to provide health care services
6 or benefits during such period and no premium may be charged
7 to the participant or beneficiary for any coverage during the
8 period. Such period begins on the enrollment date and runs
9 concurrently with any waiting period under the plan.

10 (c) As an alternative to the method authorized by
11 paragraph (a), a health maintenance organization may address
12 adverse selection in a method approved by the department.

13 (10)(a) Except as provided in paragraph (b), no period
14 before July 1, 1996, shall be taken into account in
15 determining creditable coverage.

16 (b) The department shall adopt rules that provide a
17 process whereby individuals who need to establish creditable
18 coverage for periods before July 1, 1996, and who would have
19 such coverage credited but for paragraph (a), may be given
20 credit for creditable coverage for such periods through the
21 presentation of documents or other means.

22 (11) Except as otherwise provided in this subsection,
23 the requirements of paragraph (8)(b) shall apply to events
24 that occur on or after July 1, 1996.

25 (a) In no case is a certification required to be
26 provided under paragraph (8)(b) prior to June 1, 1997.

27 (b) In the case of an event that occurs on or after
28 July 1, 1996, and before October 1, 1996, a certification is
29 not required to be provided under paragraph (8)(b), unless an
30 individual, with respect to whom the certification is required
31 to be made, requests such certification in writing.

1 (12) In the case of an individual who seeks to
2 establish creditable coverage for any period for which
3 certification is not required because it relates to an event
4 occurring before July 1, 1996:

5 (a) The individual may present evidence of other
6 creditable coverage in order to establish the period of
7 creditable coverage.

8 (b) A health maintenance organization is not subject
9 to any penalty or enforcement action with respect to the
10 organization's crediting, or not crediting, such coverage if
11 the organization has sought to comply in good faith with
12 applicable provisions of this section.

13 (13) For purposes of subsection (10), any plan
14 amendment made pursuant to a collective bargaining agreement
15 relating to the plan which amends the plan solely to conform
16 to any requirement of this section may not be treated as a
17 termination of such collective bargaining agreement.

18 Section 27. Section 641.31072, Florida Statutes, is
19 created to read:

20 641.31072 Special enrollment periods.--

21 (1) A health maintenance organization that issues a
22 group health insurance policy shall permit an employee who is
23 eligible, but not enrolled, for coverage under the terms of
24 the contract, or a dependent of such an employee if the
25 dependent is eligible but not enrolled for coverage under such
26 terms, to enroll for coverage under the terms of the contract
27 if each of the following conditions is met:

28 (a) The employee or dependent was covered under a
29 group health plan or had health insurance coverage at the time
30 coverage was previously offered to the employee or dependent.

31 For the purpose of this section, the terms "group health plan"

1 and "health insurance coverage" have the same meaning ascribed
2 in s. 2791 of the Public Health Service Act.

3 (b) The employee stated in writing at such time that
4 coverage under a group health plan or health insurance
5 coverage was the reason for declining enrollment, but only if
6 the plan sponsor or health maintenance organization, if
7 applicable, required such a statement at such time and
8 provided the employee with notice of such requirement and the
9 consequences of such requirement at such time.

10 (c) The employee's or dependent's coverage described
11 in paragraph (a):

12 1. Was under a COBRA continuation provision or
13 continuation pursuant to s. 627.6692, and the coverage under
14 such provision was exhausted; or

15 2. Was not under such a provision and the coverage was
16 terminated as a result of loss of eligibility for the
17 coverage, including legal separation, divorce, death,
18 termination of employment, or reduction in the number of hours
19 of employment, or the coverage was terminated as a result of
20 the termination of employer contributions toward such
21 coverage.

22 (d) Under the terms of the contract, the employee
23 requests such enrollment not later than 30 days after the date
24 of exhaustion of coverage described in subparagraph (c)1., or
25 termination or employer contribution described in subparagraph
26 (c)2.

27 (2) For dependent beneficiaries, if:

28 (a) A group health maintenance organization contract
29 makes coverage available with respect to a dependent of an
30 individual;

31

1 (b) The individual is a participant under the
2 contract, or has met any waiting period applicable to becoming
3 a participant under the contract, and is eligible to be
4 enrolled under the contract but for a failure to enroll during
5 a previous enrollment period; and

6 (c) A person becomes such a dependent of the
7 individual through marriage, birth, or adoption or placement
8 for adoption,

9
10 the health maintenance organization shall provide for a
11 dependent special enrollment period described in subsection
12 (3) during which the person, or, if not otherwise enrolled,
13 the individual, may be enrolled under the plan as a dependent
14 of the individual, and in the case of the birth or adoption of
15 a child, the spouse of the individual may be enrolled as a
16 dependent of the individual if such spouse is otherwise
17 eligible for coverage.

18 (3) A dependent special enrollment period under
19 subsection (2) shall be a period of not less than 30 days and
20 shall begin on the later of:

21 (a) The date dependent coverage is made available; or

22 (b) The date of the marriage, birth, or adoption or
23 placement for adoption described in subsection (2)(c).

24 (4) If an individual seeks to enroll a dependent
25 during the first 30 days of such a dependent special
26 enrollment period, the coverage of the dependent shall become
27 effective:

28 (a) In the case of marriage, not later than the first
29 day of the first month beginning after the date the completed
30 request for enrollment is received.

31

1 (b) In the case of a dependent's birth, as of the date
2 of such birth.

3 (c) In the case of a dependent's adoption or placement
4 for adoption, the date of such adoption or placement for
5 adoption.

6 Section 28. Section 641.31073, Florida Statutes, is
7 created to read:

8 641.31073 Prohibiting discrimination against
9 individual participants and beneficiaries based on health
10 status.--

11 (1) Subject to subsection (2), a health maintenance
12 organization that offers group health insurance coverage may
13 not establish rules for eligibility, including continued
14 eligibility, of an individual to enroll under the terms of the
15 contract based on any of the following health-status-related
16 factors in relation to the individual or a dependent of the
17 individual:

18 (a) Health status.

19 (b) Medical condition, including physical and mental
20 illnesses.

21 (c) Claims experience.

22 (d) Receipt of health care.

23 (e) Medical history.

24 (f) Genetic information.

25 (g) Evidence of insurability, including conditions
26 arising out of acts of domestic violence.

27 (h) Disability.

28 (2) Subsection (1) does not:

29 (a) Require a health maintenance organization to
30 provide particular benefits other than those provided under
31 the terms of such plan or coverage.

1 (b) Prevent such a plan or coverage from establishing
2 limitations or restrictions on the amount, level, extent, or
3 nature of the benefits or coverage for similarly situated
4 individuals enrolled in the plan or coverage.

5 (3) For purposes of subsection (1), rules for
6 eligibility to enroll under a contract include rules for
7 defining any applicable affiliation or waiting periods of
8 enrollment.

9 (4)(a) A health maintenance organization that offers
10 health insurance coverage may not require any individual, as a
11 condition of enrollment or continued enrollment under the
12 contract, to pay a premium or contribution that is greater
13 than such premium or contribution for a similarly situated
14 individual enrolled under the contract on the basis of any
15 health-status-related factor in relation to the individual or
16 to an individual enrolled under the contract as a dependent of
17 the individual.

18 (b) This subsection does not:

19 1. Restrict the amount that an employer may be charged
20 for coverage under a group health insurance contract.

21 2. Prevent a health maintenance organization offering
22 group health insurance coverage from establishing premium
23 discounts or rebates or modifying otherwise applicable
24 copayments or deductibles in return for adherence to programs
25 of health promotion and disease prevention.

26 Section 29. Section 641.31074, Florida Statutes, is
27 created to read:

28 641.31074 Guaranteed renewability of coverage.--

29 (1) Except as otherwise provided in this section, a
30 health maintenance organization that issues a group health
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1 insurance contract must renew or continue in force such
2 coverage at the option of the contract holder.

3 (2) A health maintenance organization may nonrenew or
4 discontinue a contract based only on one or more of the
5 following conditions:

6 (a) The contract holder has failed to pay premiums or
7 contributions in accordance with the terms of the contract or
8 the health maintenance organization has not received timely
9 premium payments.

10 (b) The contract holder has performed an act or
11 practice that constitutes fraud or made an intentional
12 misrepresentation of material fact under the terms of the
13 contract.

14 (c) The contract holder has failed to comply with a
15 material provision of the plan which relates to rules for
16 employer contributions or group participation.

17 (d) The health maintenance organization is ceasing to
18 offer coverage in such a market in accordance with subsection
19 (3) and applicable state law.

20 (e) There is no longer any enrollee in connection with
21 such plan who lives, resides, or works in the service area of
22 the health maintenance organization or in the area in which
23 the health maintenance organization is authorized to do
24 business and, in the case of the small-group market, the
25 organization would deny enrollment with respect to such plan
26 under s. 627.6699(5)(i).

27 (f) In the case of coverage that is made available
28 only through one or more bona fide associations as defined in
29 s. 627.6571(5), the membership of an employer in the
30 association, on the basis of which the coverage is provided,
31 ceases, but only if such coverage is terminated under this

1 paragraph uniformly without regard to any
2 health-status-related factor that relates to any covered
3 individuals.

4 (3)(a) A health maintenance organization may
5 discontinue offering a particular contract form for group
6 coverage offered in the small-group market or large-group
7 market only if:

8 1. The health maintenance organization provides notice
9 to each contract holder provided coverage of this form in such
10 market, and participants and beneficiaries covered under such
11 coverage, of such discontinuation at least 90 days prior to
12 the date of the discontinuation of such coverage;

13 2. The health maintenance organization offers to each
14 contract holder provided coverage of this form in such market
15 the option to purchase all other health insurance coverage
16 currently being offered by the health maintenance organization
17 in such market; and

18 3. In exercising the option to discontinue coverage of
19 this form and in offering the option of coverage under
20 subparagraph 2., the health maintenance organization acts
21 uniformly without regard to the claims experience of those
22 contract holders or any health-status-related factor that
23 relates to any participants or beneficiaries covered or new
24 participants or beneficiaries who may become eligible for such
25 coverage.

26 (b)1. In any case in which a health maintenance
27 organization elects to discontinue offering all coverage in
28 the small-group market or the large-group market, or both, in
29 this state, coverage may be discontinued by the insurer only
30 if:

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1 a. The health maintenance organization provides notice
2 to the department and to each contract holder, and
3 participants and beneficiaries covered under such coverage, of
4 such discontinuation at least 180 days prior to the date of
5 the discontinuation of such coverage; and

6 b. All health insurance issued or delivered for
7 issuance in this state in such markets are discontinued and
8 coverage under such health insurance coverage in such market
9 is not renewed.

10 2. In the case of a discontinuation under subparagraph
11 1. in a market, the health maintenance organization may not
12 provide for the issuance of any health maintenance
13 organization contract coverage in the market in this state
14 during the 5-year period beginning on the date of the
15 discontinuation of the last insurance contract not renewed.

16 (4) At the time of coverage renewal, a health
17 maintenance organization may modify the coverage for a product
18 offered:

19 (a) In the large-group market; or

20 (b) In the small-group market if, for coverage that is
21 available in such market other than only through one or more
22 bona fide associations, as defined in s. 627.6571(5), such
23 modification is consistent with s. 627.6699 and effective on a
24 uniform basis among group health plans with that product.

25 (5) In applying this section in the case of health
26 insurance coverage that is made available by a health
27 maintenance organization in the small-group market or
28 large-group market to employers only through one or more
29 associations, a reference to "contract holder" is deemed, with
30 respect to coverage provided to an employer member of the
31 association, to include a reference to such employer.

1 Section 30. Section 641.3921, Florida Statutes, is
2 amended to read:

3 641.3921 Conversion on termination of eligibility.--A
4 group health maintenance contract delivered or issued for
5 delivery in this state by a health maintenance organization
6 shall provide that a subscriber or covered dependent whose
7 coverage under the group health maintenance contract has been
8 terminated for any reason, including discontinuance of the
9 group health maintenance contract in its entirety or with
10 respect to a covered class, and who has been continuously
11 covered under the group health maintenance contract, and under
12 any group health maintenance contract providing similar
13 benefits which it replaces, for at least 3 months immediately
14 prior to termination, shall be entitled to have issued to him
15 by the health maintenance organization a health maintenance
16 contract, hereafter referred to as a "converted contract." A
17 subscriber or covered dependent shall not be entitled to have
18 a converted contract issued to him if termination of his
19 coverage under the group health maintenance contract occurred
20 for any of the following reasons:

21 (1) Failure to pay any required premium or
22 contribution unless such nonpayment of premium was due to acts
23 of an employer or person other than the individual;

24 (2) Replacement of any discontinued group coverage by
25 similar group coverage within 31 days;

26 (3) Fraud or material misrepresentation in applying
27 for any benefits under the health maintenance contract;

28 (4) Disenrollment for cause. When the requirements of
29 paragraphs (a), (b), and (c) have been met, a health
30 maintenance organization may disenroll a subscriber for cause
31 if the subscriber's behavior is disruptive, unruly, abusive,

1 or uncooperative to the extent that his continuing membership
2 in the organization seriously impairs the organization's
3 ability to furnish services to either the subscriber or other
4 subscribers.

5 (a) Effort to resolve the problem. The organization
6 must make a serious effort to resolve the problem presented by
7 the subscriber, including the use or attempted use of
8 subscriber grievance procedures.

9 (b) Consideration of extenuating circumstances. The
10 organization must ascertain that the subscriber's behavior
11 does not directly result from an existing medical condition.

12 (c) Documentation. The organization must document the
13 problems, efforts, and medical conditions as described in this
14 subsection;

15 (5) Willful and knowing misuse of the health
16 maintenance organization identification membership card by the
17 subscriber;

18 (6) Willful and knowing furnishing to the organization
19 by the subscriber of incorrect or incomplete information for
20 the purpose of fraudulently obtaining coverage or benefits
21 from the organization; or

22 (7) The subscriber has left the geographic area of the
23 health maintenance organization with the intent to relocate or
24 establish a new residence outside the organization's
25 geographic area.

26 Section 31. Section 641.3922, Florida Statutes, is
27 amended to read:

28 641.3922 Conversion contracts; conditions.--Issuance
29 of a converted contract shall be subject to the following
30 conditions:

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1 (1) TIME LIMIT.--Written application for the converted
2 contract shall be made and the first premium paid to the
3 health maintenance organization not later than 63 ~~31~~ days
4 after such termination.

5 (2) EVIDENCE OF INSURABILITY.--The converted contract
6 shall be issued without evidence of insurability.

7 (3) CONVERSION PREMIUM.--The premium for the converted
8 contract shall be determined in accordance with premium rates
9 applicable to the age and class of risk of each person to be
10 covered under the converted contract and to the type and
11 amount of coverage provided. However, the premium for the
12 converted contract may not exceed 200 percent of the standard
13 risk rate, as established by the Florida Comprehensive Health
14 Association and adjusted for differences in benefit levels and
15 structure between the converted policy and the policy offered
16 by the Florida Comprehensive Health Association. The mode of
17 payment for the converted contract shall be quarterly or more
18 frequently at the option of the organization, unless otherwise
19 mutually agreed upon between the subscriber and the
20 organization.

21 (4) EFFECTIVE DATE OF COVERAGE.--The effective date of
22 the converted contract shall be the day following the
23 termination of coverage under the group health maintenance
24 contract. However, until application is made and the first
25 premium is paid, the health maintenance organization may
26 charge the subscriber, on a fee-for-service basis, for any
27 services rendered to the subscriber after the date in which
28 the subscriber ceases to be eligible under the group health
29 maintenance contract. When application is made and the first
30 premium is paid, the organization shall reimburse the
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1 subscriber for any payment made by the subscriber for covered
2 services under the converted contract.

3 (5) SCOPE OF COVERAGE.--The converted contract shall
4 cover the subscriber or dependents who were covered by the
5 group health maintenance contract on the date of termination
6 of coverage. At the option of the health maintenance
7 organization, a separate converted contract may be issued to
8 cover any dependent.

9 (6) OPTIONAL COVERAGE.--The health maintenance
10 organization shall not be required to issue a converted
11 contract covering any person if such person is or could be
12 covered by Medicare, Title XVIII of the Social Security Act,
13 as added by the Social Security Amendments of 1965, or as
14 later amended or superseded. Furthermore, the health
15 maintenance organization shall not be required to issue a
16 converted health maintenance contract covering any person if:

17 (a)1. The person is covered for similar benefits by
18 another hospital, surgical, medical, or major medical expense
19 insurance policy or hospital or medical service subscriber
20 contract or medical practice or other prepayment plan or by
21 any other plan or program;

22 2. The person is eligible for similar benefits,
23 whether or not covered therefor, under any arrangement of
24 coverage for individuals in a group, whether on an insured or
25 uninsured basis; or

26 3. Similar benefits are provided for or are available
27 to the person pursuant to or in accordance with the
28 requirements of any state or federal law; and

29 (b) A converted health maintenance contract may
30 include a provision whereby the health maintenance
31 organization may request information, in advance of any

1 premium due date of a health maintenance contract, of any
2 person covered thereunder as to whether:

3 1. He is covered for similar benefits by another
4 hospital, surgical, medical, or major medical expense
5 insurance policy or hospital or medical service subscriber
6 contract or medical practice or other prepayment plan or by
7 any other plan or program;

8 2. He is covered for similar benefits under any
9 arrangement of coverage for individuals in a group, whether on
10 an insured or uninsured basis; or

11 3. Similar benefits are provided for or are available
12 to the person pursuant to or in accordance with the
13 requirements of any state or federal law.

14 (7) REASONS FOR CANCELLATION; TERMINATION.--The
15 converted health maintenance contract must contain a
16 cancellation or nonrenewability clause providing that the
17 health maintenance organization may refuse to renew the
18 contract of any person covered thereunder, but cancellation or
19 nonrenewal must be limited to one or more of the following
20 reasons:

21 (a) Fraud or material misrepresentation, subject to
22 the limitations of s. 641.31(23), in applying for any benefits
23 under the converted health maintenance contract;

24 (b) Eligibility of the covered person for coverage
25 under Medicare, Title XVIII of the Social Security Act, as
26 added by the Social Security Amendments of 1965, or as later
27 amended or superseded, or under any other state or federal law
28 providing for benefits similar to those provided by the
29 converted health maintenance contract, except for Medicaid,
30 Title XIX of the Social Security Act, as amended by the Social
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1 Security Amendments of 1965, or as later amended or
2 superseded.

3 (c) Disenrollment for cause, after following the
4 procedures outlined in s. 641.3921(4).

5 (d) Willful and knowing misuse of the health
6 maintenance organization identification membership card by the
7 subscriber or the willful and knowing furnishing to the
8 organization by the subscriber of incorrect or incomplete
9 information for the purpose of fraudulently obtaining coverage
10 or benefits from the organization.

11 (e) Failure, after notice, to pay required premiums.

12 (f) The subscriber has left the geographic area of the
13 health maintenance organization with the intent to relocate or
14 establish a new residence outside the organization's
15 geographic area.

16 (g) A dependent of the subscriber has reached the
17 limiting age under the converted contract, subject to
18 subsection (12); but the refusal to renew coverage shall apply
19 only to coverage of the dependent, except in the case of
20 handicapped children.

21 (h) A change in marital status that makes a person
22 ineligible under the original terms of the converted contract,
23 subject to subsection (12).

24 (8) BENEFITS OFFERED.--A health maintenance
25 organization shall not be required to issue a converted
26 contract which provides benefits in excess of those provided
27 under the group health maintenance contract from which
28 conversion is made. The converted health maintenance contract
29 shall meet the requirements of law pertaining to health
30 maintenance contracts and shall include a level of benefits
31 for minimum services which is substantially similar to the

1 level of benefits for these services included in the group
2 health maintenance organization contract from which the
3 termination is made.

4 (9) PREEXISTING CONDITION PROVISION.--The converted
5 health maintenance contract shall not exclude a preexisting
6 condition not excluded by the group contract. However, the
7 converted health maintenance contract may provide that any
8 coverage benefits thereunder may be reduced by the amount of
9 any coverage or benefits under the group health maintenance
10 contract after the termination of the person's coverage or
11 benefits thereunder. The converted health maintenance
12 contract may also include provisions so that during the first
13 coverage year the coverage or benefits under the converted
14 contract, together with the coverage or benefits under the
15 group health maintenance contract, shall not exceed those that
16 would have been provided had the individual's coverage or
17 benefits under the group contract remained in force and
18 effect.

19 (10) ALTERNATE PLANS.--The health maintenance
20 organization shall offer a standard health benefit plan as
21 established pursuant to s. 627.6699(12).The health
22 maintenance organization may, at its option, also offer
23 alternative plans for group health conversion in addition to
24 those required by this section, provided any alternative plan
25 is approved by the department or is a converted policy,
26 approved under s. 627.6675 and issued by an insurance company
27 authorized to transact insurance in this state. Approval by
28 the department of an alternative plan shall be based on
29 compliance by the alternative plan with the provisions of this
30 part and the rules promulgated thereunder, applicable

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1 provisions of the Florida Insurance Code and rules promulgated
2 thereunder, and any other applicable law.

3 (11) RETIREMENT COVERAGE.--In the event that coverage
4 would be continued under the group health maintenance contract
5 on an employee following his retirement prior to the time he
6 is or could be covered by Medicare, he may elect, in lieu of
7 such continuation of group coverage, to have the same
8 conversion rights as would apply had his coverage terminated
9 at retirement by reason of termination of employment or
10 membership.

11 (12) CONVERSION PRIVILEGE ALLOWED.--Subject to the
12 conditions set forth above, the conversion privilege shall
13 also be available:

14 (a) To the surviving spouse, if any, at the death of
15 the subscriber, with respect to the spouse and such children
16 whose coverages under the group health maintenance contract
17 terminate by reason of such death, otherwise to each surviving
18 child whose coverage under the group health maintenance
19 contract terminates by reason of such death or, if the group
20 contract provides for continuation of dependents' coverages
21 following the subscriber's death, at the end of such
22 continuation;

23 (b) To the former spouse whose coverage would
24 otherwise terminate because of annulment or dissolution of
25 marriage, if the former spouse is dependent for financial
26 support;

27 (c) To the spouse of the subscriber upon termination
28 of coverage of the spouse, while the subscriber remains
29 covered under the group health maintenance contract, by reason
30 of ceasing to be a qualified family member under the group
31 health maintenance contract, with respect to the spouse and

1 such children whose coverages under the group health
2 maintenance contract terminate at the same time; or
3 (d) To a child solely with respect to himself upon
4 termination of his coverage by reason of ceasing to be a
5 qualified family member under the group health maintenance
6 contract or under any converted contract, if a conversion
7 privilege is not otherwise provided above with respect to such
8 termination.

9 (13) GROUP COVERAGE IN LIEU OF INDIVIDUAL
10 COVERAGE.--The health maintenance organization may elect to
11 provide group health maintenance organization coverage through
12 a group converted contract in lieu of the issuance of an
13 individual converted contract.

14 (14) NOTIFICATION.--A notification of the conversion
15 privilege shall be included in each health maintenance
16 contract and in any certificate or member's handbook.

17 Section 32. (1) The changes made by this act to
18 section 641.3922, Florida Statutes, apply to conversion
19 policies offered, sold, issued, or renewed on or after January
20 1, 1998.

21 (2) An individual who was entitled on July 1, 1997, to
22 a conversion contract under section 641.3922, Florida
23 Statutes, shall be entitled on January 1, 1998, to a
24 conversion contract meeting the requirements of section
25 641.3922, Florida Statutes, as amended by this act. Such an
26 individual shall remain entitled to a conversion contract for
27 the same period of time after January 1, 1998, that the
28 individual would have remained eligible after July 1, 1997,
29 including the condition that application for coverage be made
30 within 63 days of the termination of the group coverage.
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1 Section 33. The provisions of this act fulfill an
2 important state interest.

3 Section 34. Section 627.6576, Florida Statutes, is
4 repealed.

5 Section 35. (1) Except as provided in subsection (2)
6 and as otherwise provided in this act, the changes made by
7 this act apply to policies or contracts with plan years that
8 begin on or after July 1, 1997.

9 (2) Except as provided in section 627.6561(9), (10),
10 and (11), and section 641.31071(10), (11), and (12), Florida
11 Statutes, in the case of a group health plan or group health
12 insurance contract maintained pursuant to one or more
13 collective bargaining agreements between employee
14 representatives and one or more employers which is ratified
15 before this act becomes a law, sections 627.6561, 627.65615,
16 627.65625, 627.6571, 627.6699, 641.31071, 641.31072,
17 641.31073, and 641.31074, Florida Statutes, except for section
18 627.6561(8)(b), Florida Statutes, as amended or created by
19 this act, apply to policies or contracts with plan years that
20 begin on or after the later of:

21 (a) The date on which the last of any collective
22 bargaining agreement that relates to the plan terminates,
23 determined without regard to any extension thereof, which is
24 agreed to after the date this act becomes a law; or

25 (b) July 1, 1997.

26 Section 36. The Banking and Insurance Committee of the
27 Senate and the Health Care Services Committee of the House of
28 Representatives are directed to conduct an interim study to
29 make recommendations to the Legislature for the 1998 Regular
30 Session regarding high cost insureds and potential insureds
31 and how the needs of such insureds are being met under this

1 act. The Department of Insurance is directed to assist with
2 the provision of information and the gathering of data as
3 required or deemed appropriate by the committees.
4 Section 37. The amendments in this act to s.
5 627.6487(3)(b)2., Florida Statutes, and to ss. 627.6675 and
6 641.3922, Florida Statutes, shall not take effect unless the
7 Health Care Finance Administration of the United States
8 Department of Health and Human Services approves this act as
9 providing an acceptable alternative mechanism, as provided in
10 s. 2744 of the Public Health Service Act, or the act is deemed
11 approved due to the expiration of the time periods prescribed
12 in s. 2744(b)(5) of the Public Health Service Act.
13 Section 38. Except as otherwise provided in this act,
14 this act shall take effect upon becoming a law.
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HOUSE SUMMARY

Eliminates provisions that would have required out-of-state group policies covering Florida residents to meet the new requirements in the bill that apply to group policies issued in Florida (preexisting condition limitations, special enrollment period, prohibited discrimination against individual members of a group, and guaranteed renewability).

Applies guaranteed renewability requirements for individual health insurance policies to certificates of coverage issued to individuals in Florida as part of a group policy issued to an association outside of Florida.

Applies guarantee-issue requirements that apply to individual health insurers to insurers issuing certificates of coverage issued to individuals in Florida as part of a group policy issued to an association outside of Florida.

Requires that the development of standards for compensation for agents that may be established by the Small Employer Reinsurance Program must follow criteria previously established for small group insurance. Adds two health insurance agent members to the board of the Small Employer Reinsurance Program.

Requires that persons who would have been eligible on July 1, 1997, for an individual conversion policy or HMO conversion contract or guarantee issuance of individual coverage, are eligible on January 1, 1998. Such a person remains eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997.

Authorizes HMOs to sell high-deductible contracts to employers that establish medical savings accounts.

Authorizes issuance of federally qualified long-term-care insurance contracts notwithstanding any inconsistent provisions under current Florida law. Requires disclosure to an applicant for a long-term-care policy whether the policy does, or does not, qualify for favorable federal tax treatment. Requires the Department of Insurance to adopt rules that must identify the provisions of current law that are inconsistent with the requirements for a federally qualified long-term-care policy.

Eliminates the 150 percent of standard risk rate cap on premiums for individual conversion policies and reinserts the current 200 percent cap.

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2 Changes the premium cap on HMO conversion contracts from
3 150 percent to 200 percent of the standard rate.
4 Provides that the bill fulfill an important state
5 interest.
6 Provides that conversion law changes (both both group
7 health and group HMO) take effect upon the earlier of
8 approval by the federal Health Care Finance
9 Administration (HCFA) or 90 days after submission to HCFA
10 if HCFA does not disapprove.
11 Directs the Banking and Insurance Committee of the Senate
12 and the Health Care Committee of the House of
13 Representatives to study how the needs of high cost
14 insureds and potential insureds are met by this act.
15 Provides technical conforming changes.
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