

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

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

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

1 627.9404, F.S.; providing additional  
 2 definitions; amending s. 627.9407, F.S.;  
 3 specifying additional information required to  
 4 be disclosed for purposes of long-term care  
 5 insurance; requiring a disclosure statement;  
 6 amending s. 627.94071, F.S.; specifying  
 7 additional minimum standards for home health  
 8 care benefits; amending s. 627.94072, F.S.;  
 9 deleting a requirement to provide cash  
 10 surrender values in offering long-term care  
 11 insurance policies; amending s. 627.94073,  
 12 F.S.; revising notice of cancellation  
 13 provisions; amending s. 627.94074, F.S.;  
 14 revising standards for benefit triggers;  
 15 creating s. 641.2018, F.S.; authorizing a  
 16 health maintenance organization to offer high  
 17 deductible contracts to certain employers;  
 18 amending s. 641.31, F.S.; revising requirements  
 19 for a health maintenance contract that provides  
 20 coverage for maternity care; prohibiting a  
 21 health maintenance organization from denying  
 22 eligibility to enroll or to renew coverage;  
 23 prohibiting such an organization from imposing  
 24 certain limitations on benefits, coverage, or  
 25 reimbursement; prohibiting such an organization  
 26 from providing monetary payments or rebates;  
 27 amending s. 641.3102, F.S.; prohibiting health  
 28 maintenance organizations from declining to  
 29 offer coverage to an eligible individual under  
 30 s. 627.6487, F.S.; creating s. 641.31071, F.S.,  
 31 relating to exclusions for preexisting

1 conditions; providing definitions; specifying  
 2 circumstances under which a health maintenance  
 3 organization may impose an exclusion for a  
 4 preexisting condition; providing exceptions;  
 5 providing requirements for creditable coverage;  
 6 providing for an election of methods for  
 7 calculating creditable coverage; requiring  
 8 disclosure of certain elections; providing for  
 9 establishing creditable coverage; providing  
 10 exceptions; requiring a health maintenance  
 11 organization to provide certification pursuant  
 12 to rules adopted by the department; creating s.  
 13 641.31072, F.S.; requiring a health maintenance  
 14 organization to provide for special enrollment  
 15 periods under a contract for employees and  
 16 dependents; providing conditions for special  
 17 enrollment periods; creating s. 641.31073,  
 18 F.S.; prohibiting a health maintenance  
 19 organization from discriminating against  
 20 individual participants and beneficiaries based  
 21 on health status; creating s. 641.31074, F.S.;  
 22 requiring a health maintenance organization to  
 23 renew or continue coverage of certain group  
 24 health insurance contracts; requiring notice of  
 25 discontinuation; prescribing a process for  
 26 notification; authorizing a health maintenance  
 27 organization to modify coverage; amending s.  
 28 641.3921, F.S.; clarifying circumstances under  
 29 which a health maintenance organization may  
 30 issue a converted contract; amending s.  
 31 641.3922, F.S.; revising the time limitation

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

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

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

25 627.6406 Maternity care.--

26 (1) Any policy of health insurance that provides  
27 coverage for maternity care must ~~shall~~ also cover the services  
28 of certified nurse-midwives and midwives licensed pursuant to  
29 chapter 467, and the services of birth centers licensed under  
30 ss. 383.30-383.335.  
31

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

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

19           (4) Any policy of health insurance that provides  
20 coverage, benefits, or services for maternity or newborn care  
21 must provide coverage for postdelivery care for a mother and  
22 her newborn infant. The postdelivery care must include a  
23 postpartum assessment and newborn assessment and may be  
24 provided at the hospital, at the attending physician's office,  
25 at an outpatient maternity center, or in the home by a  
26 qualified licensed health care professional trained in mother  
27 and baby care. The services must include physical assessment  
28 of the newborn and mother, and the performance of any  
29 medically necessary clinical tests and immunizations in  
30 keeping with prevailing medical standards.

31

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

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

9           (a) Deny to a mother or her newborn infant  
10 eligibility, or continued eligibility, to enroll or to renew  
11 coverage under the terms of the policy for the purpose of  
12 avoiding the requirements of this section.

13           (b) Provide monetary payments or rebates to a mother  
14 to encourage the mother to accept less than the minimum  
15 protections available under this section.

16           (c) Penalize or otherwise reduce or limit the  
17 reimbursement of an attending provider solely because the  
18 attending provider provided care to an individual participant  
19 or beneficiary in accordance with this section.

20           (d) Provide incentives, monetary or otherwise, to an  
21 attending provider solely to induce the provider to provide  
22 care to an individual participant or beneficiary in a manner  
23 inconsistent with this section.

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

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

31           1. Give birth in a hospital.



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

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

7           (c) This section does not prevent a policy from  
8 imposing deductibles, coinsurance, or other cost-sharing in  
9 relation to benefits for hospital lengths of stay in  
10 connection with childbirth for a mother or her newborn infant,  
11 except that such coinsurance or other cost-sharing for any  
12 portion of a period within a hospital length of stay required  
13 under subsection (2) may not be greater than such coinsurance  
14 or cost-sharing for any preceding portion of such stay.

15           Section 2. Section 627.6425, Florida Statutes, 1996  
16 Supplement, is amended to read:

17           (Substantial rewording of section. See  
18 s. 627.6425, F.S., 1996 Supp., for present text.)  
19 627.6425 Renewability of individual coverage.--

20           (1) Except as otherwise provided in this section, an  
21 insurer that provides individual health insurance coverage to  
22 an individual shall renew or continue in force such coverage  
23 at the option of the individual. For the purpose of this  
24 section, the term "individual health insurance" means health  
25 insurance coverage, as described in s. 627.6561(5)(a)2.,  
26 offered to an individual in this state, including certificates  
27 of coverage offered to individuals in this state as part of a  
28 group policy issued to an association outside this state, but  
29 the term does not include short-term limited duration  
30 insurance or excepted benefits specified in subsection (6) or  
31 subsection (7).

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

4           (a) The individual has failed to pay premiums or  
5 contributions in accordance with the terms of the health  
6 insurance coverage or the insurer has not received timely  
7 premium payments.

8           (b) The individual has performed an act or practice  
9 that constitutes fraud or made an intentional  
10 misrepresentation of material fact under the terms of the  
11 coverage.

12           (c) The insurer is ceasing to offer coverage in the  
13 individual market in accordance with subsection (3) and  
14 applicable state law.

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

22           (e) In the case of health insurance coverage that is  
23 made available in the individual market only through one or  
24 more bona fide associations, as defined in s. 627.6571(5), the  
25 membership of the individual in the association, on the basis  
26 of which the coverage is provided, ceases, but only if such  
27 coverage is terminated under this paragraph uniformly without  
28 regard to any health-status-related factor of covered  
29 individuals.

30           (3)(a) In any case in which an insurer decides to  
31 discontinue offering a particular policy form for health

1 insurance coverage offered in the individual market, coverage  
2 under such form may be discontinued by the insurer only if:  
3       1. The insurer provides notice to each covered  
4 individual provided coverage under this policy form in the  
5 individual market of such discontinuation at least 90 days  
6 prior to the date of the discontinuation of such coverage;  
7       2. The insurer offers to each individual in the  
8 individual market provided coverage under this policy form the  
9 option to purchase any other individual health insurance  
10 coverage currently being offered by the insurer for  
11 individuals in such market in the state; and  
12       3. In exercising the option to discontinue coverage of  
13 this policy form and in offering the option of coverage under  
14 subparagraph 2., the insurer acts uniformly without regard to  
15 any health-status-related factor of enrolled individuals or  
16 individuals who may become eligible for such coverage.  
17       (b)1. Subject to subparagraph (a)3., in any case in  
18 which an insurer elects to discontinue offering all health  
19 insurance coverage in the individual market in this state,  
20 health insurance coverage may be discontinued by the insurer  
21 only if:  
22           a. The insurer provides notice to the department and  
23 to each individual of such discontinuation at least 180 days  
24 prior to the date of the expiration of such coverage; and  
25           b. All health insurance issued or delivered for  
26 issuance in the state in the individual market is discontinued  
27 and coverage under such health insurance coverage in such  
28 market is not renewed.  
29       2. In the case of a discontinuation under subparagraph  
30 1. in the individual market, the insurer may not provide for  
31 the issuance of any individual health insurance coverage in

1 this state during the 5-year period beginning on the date of  
2 the discontinuation of the last health insurance coverage not  
3 so renewed.

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

10 (5) In applying this section in the case of health  
11 insurance coverage that is made available by an insurer in the  
12 individual market to individuals only through one or more  
13 associations, a reference to an "individual" includes a  
14 reference to such an association of which the individual is a  
15 member.

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

19 (7) The requirements of this section do not apply to  
20 any health insurance coverage in relation to its provision of  
21 excepted benefits described in s. 627.6561(5)(c), (d), or (e),  
22 if the benefits are provided under a separate policy,  
23 certificate, or contract of insurance.

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

27 Section 3. Section 627.6475, Florida Statutes, is  
28 created to read:

29 627.6475 Individual reinsurance pool.--

30 (1) PURPOSE.--The purpose of this section is to  
31 provide for the establishment of a reinsurance program for

1 coverage of individuals who are eligible for issuance of  
2 individual health insurance from a health insurance issuer  
3 pursuant to s. 627.6487.

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

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

7 (b) "Health insurance issuer," "issuer," and  
8 "individual health insurance" have the same meaning ascribed  
9 in s. 627.6487(2).

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

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

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

18 (3) APPLICABILITY AND SCOPE.--This section applies to  
19 individual health insurance offered by a health insurance  
20 issuer to an eligible individual.

21 (4) MAINTENANCE OF RECORDS.--Each health insurance  
22 issuer that offers individual health insurance must maintain  
23 at its principal place of business a complete and detailed  
24 description of its rating practices and renewal practices, as  
25 required for small employer carriers pursuant to s.  
26 627.6699(8).

27 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING  
28 CARRIER.--

29 (a) Each health insurance issuer that offers  
30 individual health insurance must elect to become a  
31 risk-assuming carrier or a reinsuring carrier for purposes of

1 this section. Each such issuer must make an initial election,  
2 binding through December 31, 1999. The issuer's initial  
3 election must be made no later than October 31, 1997. By  
4 October 31, 1997, all issuers must file a final election,  
5 which is binding for 2 years, from January 1, 1998, through  
6 December 31, 1999, after which an election shall be binding  
7 for a period of 5 years. The department may permit an issuer  
8 to modify its election at any time for good cause shown, after  
9 a hearing.

10 (b) The department shall establish an application  
11 process for issuers seeking to change their status under this  
12 subsection.

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

15 (d) An issuer that elects to cease participating as a  
16 reinsuring carrier and to become a risk-assuming carrier may  
17 not reinsure or continue to reinsure any individual health  
18 benefits plan under subsection (7) once the issuer becomes a  
19 risk-assuming carrier, and the issuer must pay a prorated  
20 assessment based upon business issued as a reinsuring carrier  
21 for any portion of the year that the business was reinsured.  
22 An issuer that elects to cease participating as a  
23 risk-assuming carrier and to become a reinsuring carrier may  
24 reinsure individual health insurance under the terms set forth  
25 in subsection (7) and must pay a prorated assessment based  
26 upon business issued as a reinsuring carrier for any portion  
27 of the year that the business was reinsured.

28 (6) ELECTION PROCESS TO BECOME A RISK-ASSUMING  
29 CARRIER.--

30 (a)1. A health insurance issuer that offers individual  
31 health insurance may become a risk-assuming carrier by filing

1 with the department a designation of election under this  
2 subsection in a format and manner prescribed by the  
3 department. The department shall approve the election of a  
4 health insurance issuer to become a risk-assuming carrier if  
5 the department finds that the issuer is capable of assuming  
6 that status pursuant to the criteria set forth in paragraph  
7 (b).

8         2. The department must approve or disapprove any  
9 designation as a risk-assuming carrier within 60 days after a  
10 filing.

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

14             1. The issuer's financial ability to support the  
15 assumption of the risk of individuals.

16             2. The issuer's history of rating and underwriting  
17 individuals.

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

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

23         (c) The department shall provide public notice of an  
24 issuer's designation of election under this subsection to  
25 become a risk-assuming carrier and shall provide at least a  
26 21-day period for public comment prior to making a decision on  
27 the election. The department shall hold a hearing on the  
28 election at the request of the issuer.

29         (d) The department may rescind the approval granted to  
30 a risk-assuming carrier under this subsection if the  
31

1 department finds that the carrier no longer meets the criteria  
2 of paragraph (b).

3 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

4 (a) The individual health reinsurance program shall  
5 operate subject to the supervision and control of the board of  
6 the small employer health reinsurance program established  
7 pursuant to s. 627.6699(11). The board shall establish a  
8 separate, segregated account for eligible individuals  
9 reinsured pursuant to this section, which account may not be  
10 commingled with the small employer health reinsurance account.

11 (b) A reinsuring carrier may reinsure with the program  
12 coverage of an eligible individual, subject to each of the  
13 following provisions:

14 1. A reinsuring carrier may reinsure an eligible  
15 individual within 60 days after commencement of the coverage  
16 of the eligible individual.

17 2. The program may not reimburse a participating  
18 carrier with respect to the claims of a reinsured eligible  
19 individual until the carrier has paid incurred claims of at  
20 least \$5,000 in a calendar year for benefits covered by the  
21 program. In addition, the reinsuring carrier is responsible  
22 for 10 percent of the next \$50,000 and 5 percent of the next  
23 \$100,000 of incurred claims during a calendar year, and the  
24 program shall reinsure the remainder.

25 3. The board shall annually adjust the initial level  
26 of claims and the maximum limit to be retained by the carrier  
27 to reflect increases in costs and utilization within the  
28 standard market for health benefit plans within the state. The  
29 adjustment may not be less than the annual change in the  
30 medical component of the "Commerce Price Index for All Urban  
31 Consumers" of the Bureau of Labor Statistics of the United



1 States Department of Labor, unless the board proposes and the  
2 department approves a lower adjustment factor.

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

5 5. The premium rate charged for reinsurance by the  
6 program to a health maintenance organization that is approved  
7 by the Secretary of Health and Human Services as a federally  
8 qualified health maintenance organization pursuant to 42  
9 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to  
10 requirements that limit the amount of risk that may be ceded  
11 to the program, which requirements are more restrictive than  
12 subparagraph 2., shall be reduced by an amount equal to that  
13 portion of the risk, if any, which exceeds the amount set  
14 forth in subparagraph 2., which may not be ceded to the  
15 program.

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

20 7. A reinsuring carrier shall apply its  
21 case-management and claims-handling techniques, including, but  
22 not limited to, utilization review, individual case  
23 management, preferred provider provisions, other managed-care  
24 provisions, or methods of operation consistently with both  
25 reinsured business and nonreinsured business.

26 (c)1. The board, as part of the plan of operation,  
27 shall establish a methodology for determining premium rates to  
28 be charged by the program for reinsuring eligible individuals  
29 pursuant to this section. The methodology must include a  
30 system for classifying individuals which reflects the types of  
31 case characteristics commonly used by carriers in this state.

1 The methodology must provide for the development of basic  
 2 reinsurance premium rates, which shall be multiplied by the  
 3 factors set for them in this paragraph to determine the  
 4 premium rates for the program. The basic reinsurance premium  
 5 rates shall be established by the board, subject to the  
 6 approval of the department, and shall be set at levels that  
 7 reasonably approximate gross premiums charged to eligible  
 8 individuals for individual health insurance by health  
 9 insurance issuers. The premium rates set by the board may vary  
 10 by geographical area, as determined under this section, to  
 11 reflect differences in cost. An eligible individual may be  
 12 reinsured for a rate that is five times the rate established  
 13 by the board.

14 2. The board shall periodically review the methodology  
 15 established, including the system of classification and any  
 16 rating factors, to ensure that it reasonably reflects the  
 17 claims experience of the program. The board may propose  
 18 changes to the rates that are subject to the approval of the  
 19 department.

20 (d) If individual health insurance for an eligible  
 21 individual is entirely or partially reinsured with the program  
 22 pursuant to this section, the premium charged to the eligible  
 23 individual for any rating period for the coverage issued must  
 24 be the same premium that would have been charged to that  
 25 individual if the health insurance issuer elected not to  
 26 reinsure coverage for that individual.

27 (e)1. Before March 1 of each calendar year, the board  
 28 shall determine and report to the department the program net  
 29 loss in the individual account for the previous year,  
 30 including administrative expenses for that year and the  
 31

1 incurred losses for that year, taking into account investment  
2 income and other appropriate gains and losses.

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

5 a. The operating losses of the program shall be  
6 assessed in the following order subject to the specified  
7 limitations. The first tier of assessments shall be made  
8 against reinsuring carriers in an amount that may not exceed 5  
9 percent of each reinsuring carrier's premiums for individual  
10 health insurance. If such assessments have been collected and  
11 additional moneys are needed, the board shall make a second  
12 tier of assessments in an amount that may not exceed 0.5  
13 percent of each carrier's health benefit plan premiums.

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

19 c. The board shall equitably assess reinsuring  
20 carriers for operating losses of the individual account based  
21 on market share. The board shall annually assess each carrier  
22 a portion of the operating losses of the individual account.  
23 The first tier of assessments shall be determined by  
24 multiplying the operating losses by a fraction, the numerator  
25 of which equals the reinsuring carrier's earned premium  
26 pertaining to direct writings of individual health insurance  
27 in the state during the calendar year for which the assessment  
28 is levied, and the denominator of which equals the total of  
29 all such premiums earned by reinsuring carriers in the state  
30 during that calendar year. The second tier of assessments  
31 shall be based on the premiums that all carriers, except

1 risk-assuming carriers, earned on all health benefit plans  
 2 written in this state. The board may levy interim assessments  
 3 against reinsuring carriers to ensure the financial ability of  
 4 the plan to cover claims expenses and administrative expenses  
 5 paid or estimated to be paid in the operation of the plan for  
 6 the calendar year prior to the association's anticipated  
 7 receipt of annual assessments for that calendar year. Any  
 8 interim assessment is due and payable within 30 days after  
 9 receipt by a carrier of the interim assessment notice. Interim  
 10 assessment payments shall be credited against the carrier's  
 11 annual assessment. Health benefit plan premiums and benefits  
 12 paid by a carrier that are less than an amount determined by  
 13 the board to justify the cost of collection may not be  
 14 considered for purposes of determining assessments.

15 d. Subject to the approval of the department, the  
 16 board shall adjust the assessment formula for reinsuring  
 17 carriers that are approved as federally qualified health  
 18 maintenance organizations by the Secretary of Health and Human  
 19 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,  
 20 if any, that restrictions are placed on them which are not  
 21 imposed on other carriers.

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

26 4. If the board determines that the assessments needed  
 27 to fund the losses incurred by the program in the individual  
 28 account for the previous calendar year will exceed the amount  
 29 specified in subparagraph 2., the board shall evaluate the  
 30 operation of the program and report its findings and  
 31 recommendations to the department in the format established in

1 s. 627.6699(11) for the comparable report for the small  
2 employer reinsurance program.

3 (f) Notwithstanding paragraph (e), the administrative  
4 expenses of the program shall be recouped by assessing  
5 risk-assuming carriers and reinsuring carriers, and such  
6 amounts may not be considered part of the operating losses of  
7 the plan for the purposes of this paragraph. Each carrier's  
8 portion of such administrative expenses shall be determined by  
9 multiplying the total of such administrative expenses by a  
10 fraction, the numerator of which equals the carrier's earned  
11 premium pertaining to direct writing of individual health  
12 benefit plans in the state during the calendar year for which  
13 the assessment is levied, and the denominator of which equals  
14 the total of such premiums earned by all carriers in the state  
15 during such calendar year.

16 (g) Except as otherwise provided in this section, the  
17 board and the department shall have all powers, duties, and  
18 responsibilities with respect to carriers that issue and  
19 reinsure individual health insurance, as specified for the  
20 board and the department in s. 627.6699(11) with respect to  
21 small employer carriers, including, but not limited to, the  
22 provisions of s. 627.6699(11) relating to:

23 1. Use of assessments that exceed the amount of actual  
24 losses and expenses.

25 2. The annual determination of each carrier's  
26 proportion of the assessment.

27 3. Interest for late payment of assessments.

28 4. Authority for the department to approve deferment  
29 of an assessment against a carrier.

30 5. Limited immunity from legal actions or carriers.

31

1           6. Development of standards for compensation to be  
2 paid to agents. Such standards shall be limited to those  
3 specifically enumerated in s. 627.6699(13)(d).

4           7. Monitoring compliance by carriers with this  
5 section.

6           (8) STANDARDS TO ASSURE FAIR MARKETING.--

7           (a) Each health insurance issuer that offers  
8 individual health insurance shall actively market coverage to  
9 eligible individuals in the state. The provisions of s.  
10 627.6699(13) that apply to small employer carriers that market  
11 policies to small employers shall also apply to health  
12 insurance issuers that offer individual health insurance with  
13 respect to marketing policies to individuals.

14           (b) A violation of this section by a health insurance  
15 issuer or an agent is an unfair trade practice under s.  
16 626.9541 or ss. 641.3903 and 641.3907.

17           (9) RULEMAKING AUTHORITY.--The department may adopt  
18 rules to administer this section, including rules governing  
19 compliance by carriers.

20           Section 4. Section 627.6487, Florida Statutes, is  
21 created to read:

22           627.6487 Guaranteed availability of individual health  
23 insurance coverage to eligible individuals.--

24           (1) Subject to the requirements of this section, each  
25 health insurance issuer that offers individual health  
26 insurance coverage in this state may not, with respect to an  
27 eligible individual who desires to enroll in individual health  
28 insurance coverage:

29           (a) Decline to offer such coverage to, or deny  
30 enrollment of, such individual; or

31

1           **(b) Impose any preexisting condition exclusion with**  
2 **respect to such coverage. For purposes of this section, the**  
3 **term "preexisting condition" means, with respect to coverage,**  
4 **a limitation of benefits relating to a condition based on the**  
5 **fact that the condition was present before the date of**  
6 **enrollment for such coverage, whether or not any medical**  
7 **advice, diagnosis, care, or treatment was recommended or**  
8 **received before such date.**

9           **(2) For the purposes of this section:**

10           **(a) "Health insurance issuer" and "issuer" mean an**  
11 **authorized insurer or a health maintenance organization.**

12           **(b) "Individual health insurance" means health**  
13 **insurance, as defined in s. 627.6561(5)(a)2., which is offered**  
14 **to an individual, including certificates of coverage offered**  
15 **to individuals in this state as part of a group policy issued**  
16 **to an association outside this state, but the term does not**  
17 **include short-term limited duration insurance or excepted**  
18 **benefits specified in s. 624.6561(5)(b) or, if the benefits**  
19 **are provided under a separate policy, certificate, or**  
20 **contract, the term does not include excepted benefits**  
21 **specified in s. 627.6561(5)(c), (d), or (e).**

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

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

28           **2. Whose most recent prior creditable coverage was**  
29 **under a group health plan, governmental plan, or church plan,**  
30 **or health insurance coverage offered in connection with any**  
31 **such plan;**

- 1           (b) Who is not eligible for coverage under:  
2            1. A group health plan, as defined in section 2791, of  
3 the Public Health Service Act;  
4            2. A conversion policy under s. 627.6675 or s.  
5 641.3921;  
6            3. Medicare, part A or part B of Title XVIII of the  
7 Social Security Act as amended; or  
8            4. A state plan under Medicaid, Title XIX of the  
9 Social Security Act, as amended, or any successor program,  
10  
11 and does not have other health insurance coverage;  
12           (c) With respect to whom the most recent coverage  
13 within the coverage period described in paragraph (1)(a) was  
14 not terminated based on a factor described in s.  
15 627.6571(2)(a) or (b), relating to nonpayment of premiums or  
16 fraud, unless such nonpayment of premiums or fraud was due to  
17 acts of an employer or person other than the individual;  
18           (d) Who, having been offered the option of  
19 continuation coverage under a COBRA continuation provision or  
20 under s. 627.6692, elected such coverage; and  
21           (e) Who, if the individual elected such continuation  
22 provision, has exhausted such continuation coverage under such  
23 provision or program.  
24           (4)(a) The health insurance issuer may elect to limit  
25 the coverage offered under subsection (1) if the issuer offers  
26 at least two different policy forms of health insurance  
27 coverage, both of which:  
28            1. Are designed for, made generally available to,  
29 actively marketed to, and enroll both eligible and other  
30 individuals by the issuer; and  
31            2. Meet the requirement of paragraph (b).



1  
2 For purposes of this subsection, policy forms that have  
3 different cost-sharing arrangements or different riders are  
4 considered to be different policy forms.

5 (b) The requirement of this subsection is met for  
6 health insurance coverage policy forms offered by an issuer in  
7 the individual market if the issuer offers the policy forms  
8 for individual health insurance coverage with the largest, and  
9 next to largest, premium volume of all such policy forms  
10 offered by the issuer in this state or applicable marketing or  
11 service area, as prescribed in rules adopted by the  
12 department, in the individual market in the period involved.  
13 To the greatest extent possible, such rules must be consistent  
14 with regulations adopted by the United States Department of  
15 Health and Human Services.

16 (5)(a) In the case of a health insurance issuer that  
17 offers individual health insurance coverage through a network  
18 plan, the issuer may:

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

22 2. Within the service area of such plan, deny such  
23 coverage to such individuals if the issuer has demonstrated to  
24 the department that:

25 a. It will not have the capacity to deliver services  
26 adequately to additional individual enrollees because of its  
27 obligations to existing group contract holders and enrollees  
28 and individual enrollees; and

29 b. It is applying this paragraph uniformly to  
30 individuals without regard to any health-status-related factor  
31

1 of such individuals and without regard to whether the  
2 individuals are eligible individuals.

3 (b) An issuer, upon denying individual health  
4 insurance coverage in any service area in accordance with  
5 subparagraph (a)2., may not offer coverage in the individual  
6 market within such service area for a period of 180 days after  
7 such coverage is denied.

8 (6)(a) A health insurance issuer may deny individual  
9 health insurance coverage to an eligible individual if the  
10 issuer has demonstrated to the department that:

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

13 2. It is applying this paragraph uniformly to all  
14 individuals in the individual market in this state consistent  
15 with the laws of this state and without regard to any  
16 health-status-related factor of such individuals and without  
17 regard to whether the individuals are eligible individuals.

18 (b) An issuer, upon denying individual health  
19 insurance coverage in any service area in accordance with  
20 paragraph (a), may not offer such coverage in the individual  
21 market within such service area for a period of 180 days after  
22 the date such coverage is denied or until the issuer has  
23 demonstrated to the department that the issuer has sufficient  
24 financial reserves to underwrite additional coverage,  
25 whichever occurs later.

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

31

1           (b) A health insurance issuer that offers health  
2 insurance coverage in connection with group health plans is  
3 not deemed to be a health insurance issuer offering individual  
4 health insurance coverage solely because such issuer offers a  
5 conversion policy.

6           (8) This section does not:

7           (a) Restrict the amount of the premium rates that an  
8 issuer may charge an individual for individual health  
9 insurance coverage; or

10           (b) Prevent a health insurance issuer that offers  
11 individual health insurance coverage from establishing premium  
12 discounts or rebates or modifying otherwise applicable  
13 copayments or deductibles in return for adherence to programs  
14 of health promotion and disease prevention.

15           (9) Each health insurance issuer that offers  
16 individual health insurance coverage to an eligible individual  
17 shall elect to become a risk-assuming carrier or a reinsuring  
18 carrier, as provided by s. 627.6475.

19           (10) This section applies to individual health  
20 insurance coverage offered on or after January 1, 1998. An  
21 individual who would have been eligible for coverage on July  
22 1, 1997, shall be eligible for coverage on January 1, 1998,  
23 and shall remain eligible for the same period of time after  
24 January 1, 1998, that the individual would have remained  
25 eligible for coverage after July 1, 1997.

26           Section 5. Section 627.64871, Florida Statutes, is  
27 created to read:

28           627.64871 Certification of coverage.--

29           (1) Section 627.6561(8), applies to health insurance  
30 coverage offered by an insurer in the individual market in the  
31 same manner as it applies to health insurance coverage offered

1 by an insurer in connection with a group health plan in the  
2 small-group market or large-group market.

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

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

11 (4) This section applies to health insurance coverage  
12 offered, sold, issued, renewed, or in effect on or after July  
13 1, 1997.

14 Section 6. Section 627.6489, Florida Statutes, is  
15 created to read:

16 627.6489 Disease Management Program.--

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

20 (2) An insurer that elects to contract for such  
21 services shall provide the association with all medical  
22 records and claims information necessary for the association  
23 to effectively manage the services.

24 (3) Monies collected by the association for providing  
25 disease management services shall be used by the association  
26 to pay administrative expenses associated with the disease  
27 management program and to reduce any deficits incurred by the  
28 association. No funds received at any time by the association  
29 as a result of assessments against insurers may be used in  
30 connection with the disease management program. No costs  
31

1 related to the disease management program provided to an  
2 insurer shall be assessed against any other insurer.

3 Section 7. Section 627.6512, Florida Statutes, is  
4 created to read:

5 627.6512 Exemption of certain group health insurance  
6 policies.--Sections 627.6561, 627.65615, 627.65625, and  
7 627.6571, do not apply to:

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

10 (2) Any group health insurance policy in relation to  
11 its provision of excepted benefits described in s.  
12 627.6561(5)(c), if the benefits:

13 (a) Are provided under a separate policy, certificate,  
14 or contract of insurance; or

15 (b) Are otherwise not an integral part of the policy.

16 (3) Any group health insurance policy in relation to  
17 its provision of excepted benefits described in s.  
18 627.6561(5)(d), if all of the following conditions are met:

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

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

24 (c) Such benefits are paid with respect to an event  
25 without regard to whether benefits are provided with respect  
26 to such an event under any group health policy maintained by  
27 the same policyholder.

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

1           Section 8. Section 627.6561, Florida Statutes, is  
2 amended to read:

3           (Substantial rewording of section. See  
4           s. 627.6561, F.S., for present text.)  
5           627.6561 Preexisting conditions.--

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

7           (a) "Enrollment date" means, with respect to an  
8 individual covered under a group health policy, the date of  
9 enrollment of the individual in the plan or coverage or, if  
10 earlier, the first day of the waiting period of such  
11 enrollment.

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

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

17           2. A special enrollment period, as provided under s.  
18 627.65615.

19           (c) "Waiting period" means, with respect to a group  
20 health policy and an individual who is a potential participant  
21 or beneficiary of the policy, the period that must pass with  
22 respect to the individual before the individual is eligible to  
23 be covered for benefits under the terms of the policy.

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

28           (a) Such exclusion relates to a physical or mental  
29 condition, regardless of the cause of the condition, for which  
30 medical advice, diagnosis, care, or treatment was recommended  
31

1 or received within the 6-month period ending on the enrollment  
2 date;

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

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

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

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

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

19 2. A child who is adopted or placed for adoption  
20 before attaining 18 years of age and who, as of the last day  
21 of the 30-day period beginning on the date of the adoption or  
22 placement for adoption, is covered under creditable coverage.  
23 This provision does not apply to coverage before the date of  
24 such adoption or placement for adoption.

25 3. Pregnancy.

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

30  
31

1           (5)(a) The term, "creditable coverage," means, with  
2 respect to an individual, coverage of the individual under any  
3 of the following:

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

6           2. Health insurance coverage consisting of medical  
7 care, provided directly, through insurance or reimbursement,  
8 or otherwise and including terms and services paid for as  
9 medical care, under any hospital or medical service policy or  
10 certificate, hospital or medical service plan contract, or  
11 health maintenance contract offered by a health insurance  
12 issuer.

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

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

18           5. Chapter 55 of Title 10, United States Code.

19           6. A medical care program of the Indian Health Service  
20 or of a tribal organization.

21           7. The Florida Comprehensive Health Association or  
22 another state health benefit risk pool.

23           8. A health plan offered under chapter 89 of Title 5,  
24 United States Code.

25           9. A public health plan as defined by rules adopted by  
26 the department. To the greatest extent possible, such rules  
27 must be consistent with regulations adopted by the United  
28 States Department of Health and Human Services.

29           10. A health benefit plan under s. 5(e) of the Peace  
30 Corps Act (22 United States Code, 2504(e)).

31



1           (b) Creditable coverage does not include coverage that  
2 consists solely of one or more or any combination thereof of  
3 the following excepted benefits:

4           1. Coverage only for accident, or disability income  
5 insurance, or any combination thereof.

6           2. Coverage issued as a supplement to liability  
7 insurance.

8           3. Liability insurance, including general liability  
9 insurance and automobile liability insurance.

10           4. Workers' compensation or similar insurance.

11           5. Automobile medical payment insurance.

12           6. Credit-only insurance.

13           7. Coverage for onsite medical clinics, including  
14 prepaid health clinics under part II of chapter 641.

15           8. Other similar insurance coverage, specified in  
16 rules adopted by the department, under which benefits for  
17 medical care are secondary or incidental to other insurance  
18 benefits. To the extent possible, such rules must be  
19 consistent with regulations adopted by the United States  
20 Department of Health and Human Services.

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

23           1. Limited scope dental or vision benefits.

24           2. Benefits for long-term care, nursing home care,  
25 home health care, community-based care, or any combination  
26 thereof.

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

29           (d) The following benefits do not constitute  
30 creditable coverage if offered as independent, noncoordinated  
31 benefits:

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

2           2. Hospital indemnity or other fixed indemnity  
3 insurance.

4           (e) Benefits provided through a Medicare supplemental  
5 health insurance, as defined under s. 1882(g)(1) of the Social  
6 Security Act, coverage supplemental to the coverage provided  
7 under chapter 55 of Title 10, United States Code, and similar  
8 supplemental coverage provided to coverage under a group  
9 health plan are not considered creditable coverage if offered  
10 as a separate insurance policy.

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

16           (b) Any period during which an individual is in a  
17 waiting period for any coverage under a group health plan or  
18 for group health insurance coverage may not be taken into  
19 account in determining the 63-day period under paragraph (a)  
20 or paragraph (4)(b).

21           (7)(a) Except as otherwise provided under paragraph  
22 (b), an insurer shall count a period of creditable coverage  
23 without regard to the specific benefits covered under the  
24 period.

25           (b) An insurer may elect to count, as creditable  
26 coverage, coverage of benefits within each of several classes  
27 or categories of benefits specified in rules adopted by the  
28 department rather than as provided under paragraph (a). To the  
29 extent possible, such rules must be consistent with  
30 regulations adopted by the United States Department of Health  
31 and Human Services. Such election shall be made on a uniform

1 basis for all participants and beneficiaries. Under such  
2 election, an insurer shall count a period of creditable  
3 coverage with respect to any class or category of benefits if  
4 any level of benefits is covered within such class or  
5 category.

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

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

12 2. Include in such statements a description of the  
13 effect of this election.

14 (8)(a) Periods of creditable coverage with respect to  
15 an individual shall be established through presentation of  
16 certifications described in this subsection or in such other  
17 manner as is specified in rules adopted by the department. To  
18 the extent possible, such rules must be consistent with  
19 regulations adopted by the United States Department of Health  
20 and Human Services.

21 (b) An insurer that offers group health insurance  
22 coverage shall provide the certification described in  
23 paragraph (a):

24 1. At the time an individual ceases to be covered  
25 under the plan or otherwise becomes covered under a COBRA  
26 continuation provision or continuation pursuant to s.  
27 627.6692.

28 2. In the case of an individual becoming covered under  
29 a COBRA continuation provision or pursuant to s. 627.6692, at  
30 the time the individual ceases to be covered under such a  
31 provision.

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

4  
5 The certification under subparagraph 1. may be provided, to  
6 the extent practicable, at a time consistent with notices  
7 required under any applicable COBRA continuation provision or  
8 continuation pursuant to s. 627.6692.

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

11           1. The period of creditable coverage of the individual  
12 under the policy and the coverage, if any, under such COBRA  
13 continuation provision or continuation pursuant to s.  
14 627.6692; and

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

17           (d) In the case of an election described in subsection  
18 (7) by an insurer, if the insurer enrolls an individual for  
19 coverage under the plan and the individual provides a  
20 certification of coverage of the individual, as provided in  
21 this subsection:

22           1. Upon request of such insurer, the insurer that  
23 issued the certification provided by the individual shall  
24 promptly disclose to such requesting plan or insurer  
25 information on coverage of classes and categories of health  
26 benefits available under such insurer's plan or coverage.

27           2. Such insurer may charge the requesting insurer for  
28 the reasonable cost of disclosing such information.

29           (e) The department shall adopt rules to prevent an  
30 insurer's failure to provide information under this subsection  
31 with respect to previous coverage of an individual from

1 adversely affecting any subsequent coverage of the individual  
2 under another group health plan or health insurance coverage.  
3 To the greatest extent possible, such rules must be consistent  
4 with regulations adopted by the United States Department of  
5 Health and Human Services.

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

9 (b) The department shall adopt rules that provide a  
10 process whereby individuals who need to establish creditable  
11 coverage for periods before July 1, 1996, and who would have  
12 such coverage credited but for paragraph (a), may be given  
13 credit for creditable coverage for such periods through the  
14 presentation of documents or other means. To the greatest  
15 extent possible, such rules must be consistent with  
16 regulations adopted by the United States Department of Health  
17 and Human Services.

18 (10) Except as otherwise provided in this subsection,  
19 paragraph (8)(b) applies to events that occur on or after July  
20 1, 1996.

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

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

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

1        (a) The individual may present evidence of other  
2 creditable coverage in order to establish the period of  
3 creditable coverage.

4        (b) An insurer is not subject to any penalty or  
5 enforcement action with respect to the insurer's crediting, or  
6 not crediting, such coverage if the insurer has sought to  
7 comply in good faith with applicable provisions of this  
8 section.

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

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

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

22        (15) This section applies to health insurance coverage  
23 offered, sold, issued, renewed, or in effect on or after July  
24 1, 1997.

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

27        627.65615 Special enrollment periods.--

28        (1) An insurer that issues a group health insurance  
29 policy shall permit an employee who is eligible, but not  
30 enrolled, for coverage under the terms of the policy, or a  
31 dependent of such an employee if the dependent is eligible but

1 not enrolled for coverage under such terms, to enroll for  
2 coverage under the terms of the policy if each of the  
3 following conditions is met:

4 (a) The employee or dependent was covered under a  
5 group health plan or had health insurance coverage at the time  
6 coverage was previously offered to the employee or dependent.  
7 For the purpose of this section, the terms "group health plan"  
8 and "health insurance coverage" have the same meaning ascribed  
9 in s. 2791 of the Public Health Service Act.

10 (b) The employee stated in writing at such time that  
11 coverage under a group health plan or health insurance  
12 coverage was the reason for declining enrollment, but only if  
13 the plan sponsor or insurer, if applicable, required such a  
14 statement at such time and provided the employee with notice  
15 of such requirement and the consequences of such requirement  
16 at such time.

17 (c) The employee's or dependent's coverage described  
18 in paragraph (a):

19 1. Was under a COBRA continuation provision or  
20 continuation pursuant to s. 627.6692, and the coverage under  
21 such provision was exhausted; or

22 2. Was not under such a provision and the coverage was  
23 terminated as a result of loss of eligibility for the  
24 coverage, including legal separation, divorce, death,  
25 termination of employment, or reduction in the number of hours  
26 of employment, or the coverage was terminated as a result of  
27 the termination of employer contributions toward such  
28 coverage.

29 (d) Under the terms of the plan, the employee requests  
30 such enrollment not later than 30 days after the date of  
31 exhaustion of coverage described in subparagraph (c)1., or

1 termination or employer contribution described in subparagraph  
2 (c)2.

3 (2) For dependent beneficiaries, if:

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

6 (b) The individual is a participant under the policy,  
7 or has met any waiting period applicable to becoming a  
8 participant under the policy, and is eligible to be enrolled  
9 under the policy but for a failure to enroll during a previous  
10 enrollment period; and

11 (c) A person becomes such a dependent of the  
12 individual through marriage, birth, or adoption or placement  
13 for adoption,

14  
15 the insurer shall provide for a dependent special enrollment  
16 period described in subsection (3) during which the person,  
17 or, if not otherwise enrolled, the individual, may be enrolled  
18 under the policy as a dependent of the individual, and in the  
19 case of the birth or adoption of a child, the spouse of the  
20 individual may be enrolled as a dependent of the individual if  
21 such spouse is otherwise eligible for coverage.

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

25 (a) The date that dependent coverage is made  
26 available; or

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

29 (4) If an individual seeks to enroll a dependent  
30 during the first 30 days of such a dependent special

31



1 enrollment period, the coverage of the dependent shall become  
2 effective:

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

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

8 (c) In the case of dependent's adoption or placement  
9 for adoption, the date of such adoption or placement for  
10 adoption.

11 Section 10. Section 627.65625, Florida Statutes, is  
12 created to read:

13 627.65625 Prohibiting discrimination against  
14 individual participants and beneficiaries based on health  
15 status.--

16 (1) Subject to subsection (2), an insurer that offers  
17 a group health insurance policy may not establish rules for  
18 eligibility, including continued eligibility, of an individual  
19 to enroll under the terms of the policy based on any of the  
20 following health-status-related factors in relation to the  
21 individual or a dependent of the individual:

22 (a) Health status.

23 (b) Medical condition, including physical and mental  
24 illnesses.

25 (c) Claims experience.

26 (d) Receipt of health care.

27 (e) Medical history.

28 (f) Genetic information.

29 (g) Evidence of insurability, including conditions  
30 arising out of acts of domestic violence.

31 (h) Disability.

1           (2) Subsection (1) does not:

2           (a) Require an insurer to provide particular benefits  
3 other than those provided under the terms of such plan or  
4 coverage.

5           (b) Prevent such a plan or coverage from establishing  
6 limitations or restrictions on the amount, level, extent, or  
7 nature of the benefits or coverage for similarly situated  
8 individuals enrolled in the plan or coverage.

9           (3) For purposes of subsection (1), rules for  
10 eligibility to enroll under a policy include rules for  
11 defining any applicable waiting periods of enrollment.

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

20           (b) This subsection does not:

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

23           2. Prevent an insurer that offers group health  
24 insurance coverage from establishing premium discounts or  
25 rebates or modifying otherwise applicable copayments or  
26 deductibles in return for adherence to programs of health  
27 promotion and disease prevention.

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

30           627.6571 Guaranteed renewability of coverage.--

31

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

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

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

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

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

18           (d) The insurer is ceasing to offer a particular type  
19 of coverage in a market in accordance with subsection (3).

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

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

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

4 (3)(a) An insurer may discontinue offering a  
5 particular policy form of group health insurance coverage  
6 offered in the small-group market or large-group market only  
7 if:

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

13 2. The insurer offers to each policyholder provided  
14 coverage of this form in such market the option to purchase  
15 all, or in the case of the large-group market, any other  
16 health insurance coverage currently being offered by the  
17 insurer 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 insurer acts uniformly without regard to  
21 the claims experience of those policyholders or any  
22 health-status-related factor that relates to any participants  
23 or beneficiaries covered or new participants or beneficiaries  
24 who may become eligible for such coverage.

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

30 a. The insurer provides notice to the department and  
31 to each policyholder, and participants and beneficiaries

1 covered under such coverage, of such discontinuation at least  
2 180 days prior to the date of the discontinuation of such  
3 coverage; and

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

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

13 (c) A mailing to one household constitutes a mailing  
14 to all covered persons residing in that household. A separate  
15 mailing is required for each separate household.

16 (4) At the time of coverage renewal, an insurer may  
17 modify the health insurance coverage for a product offered:

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

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

24 (5) As used in this section, the term "bona fide  
25 association" means an association that:

26 (a) Has been actively in existence for at least 5  
27 years;

28 (b) Has been formed and maintained in good faith for  
29 purposes other than obtaining insurance;

30 (c) Does not condition membership in the association  
31 on any health-status-related factor that relates to an

1 individual, including an employee of an employer or a  
2 dependent of an employee;

3 (d) Makes health insurance coverage offered through  
4 the association available to all members regardless of any  
5 health-status-related factor that relates to such members or  
6 individuals eligible for coverage through a member; and

7 (e) Does not make health insurance coverage offered  
8 through the association available other than in connection  
9 with a member of the association.

10 (6) In applying this section in the case of health  
11 insurance coverage that is made available by an insurer in the  
12 small-group market or large-group market to employers only  
13 through one or more associations, a reference to  
14 "policyholder" is deemed, with respect to coverage provided to  
15 an employer member of the association, to include a reference  
16 to such employer.

17 Section 12. Section 627.6574, Florida Statutes, 1996  
18 Supplement, is amended to read:

19 627.6574 Maternity care.--

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

25 (2) Any group, blanket, or franchise policy of health  
26 insurance that provides maternity and newborn coverage may not  
27 limit coverage for the length of a maternity and newborn stay  
28 in a hospital or for followup care outside of a hospital to  
29 any time period that is less than that determined to be  
30 medically necessary, in accordance with prevailing medical  
31 standards and consistent with ~~proposed 1996~~ guidelines for

1 perinatal care of the American Academy of Pediatrics or the  
 2 American College of Obstetricians and Gynecologists ~~as~~  
 3 ~~proposed on May 1, 1996~~, by the treating obstetrical care  
 4 provider or the pediatric care provider.

5 (3) ~~Nothing in~~ This section does not affect ~~affects~~  
 6 any agreement between an insurer and a hospital or other  
 7 health care provider with respect to reimbursement for health  
 8 care services provided, rate negotiations with providers, or  
 9 capitation of providers, and this section does not prohibit ~~or~~  
 10 ~~prohibits~~ appropriate utilization review or case management by  
 11 an insurer.

12 (4) Any group, blanket, or franchise policy of health  
 13 insurance that provides coverage, benefits, or services for  
 14 maternity or newborn care must provide coverage for  
 15 postdelivery care for a mother and her newborn infant. The  
 16 postdelivery care must include a postpartum assessment and  
 17 newborn assessment and may be provided at the hospital, at the  
 18 attending physician's office, at an outpatient maternity  
 19 center, or in the home by a qualified licensed health care  
 20 professional trained in mother and baby care. The services  
 21 must include physical assessment of the newborn and mother,  
 22 and the performance of any medically necessary clinical tests  
 23 and immunizations in keeping with prevailing medical  
 24 standards.

25 (5) An insurer subject to subsection (1) shall  
 26 communicate active case questions and concerns regarding  
 27 postdelivery care directly to the treating physician or  
 28 hospital in written form, in addition to other forms of  
 29 communication. Such insurers shall also use a process that  
 30 ~~which~~ includes a written protocol for utilization review and  
 31 quality assurance.

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

2           (a) Deny to a mother or her newborn infant  
3 eligibility, or continued eligibility, to enroll or to renew  
4 coverage under the terms of the policy for the purpose of  
5 avoiding the requirements of this section.

6           (b) Provide monetary payments or rebates to a mother  
7 to encourage the mother to accept less than the minimum  
8 protections available under this section.

9           (c) Penalize or otherwise reduce or limit the  
10 reimbursement of an attending provider solely because the  
11 attending provider provided care to an individual participant  
12 or beneficiary in accordance with this section.

13           (d) Provide incentives, monetary or otherwise, to an  
14 attending provider solely to induce the provider to provide  
15 care to an individual participant or beneficiary in a manner  
16 inconsistent with this section.

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

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

- 24           1. Give birth in a hospital.  
25           2. Stay in the hospital for a fixed period of time  
26 following the birth of her infant.

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

31



1           (c) This section does not prevent a policy from  
2 imposing deductibles, coinsurance, or other cost-sharing in  
3 relation to benefits for hospital lengths of stay in  
4 connection with childbirth for a mother or her newborn infant,  
5 except that such coinsurance or other cost-sharing for any  
6 portion of a period within a hospital length of stay required  
7 under subsection (2) may not be greater than such coinsurance  
8 or cost-sharing for any preceding portion of such stay.

9           Section 13. Subsection (1), paragraph (a) of  
10 subsection (3), and subsection (11) of section 627.6675,  
11 Florida Statutes, are amended, to read:

12           627.6675 Conversion on termination of  
13 eligibility.--Subject to all of the provisions of this  
14 section, a group policy delivered or issued for delivery in  
15 this state by an insurer or nonprofit health care services  
16 plan that provides, on an expense-incurred basis, hospital,  
17 surgical, or major medical expense insurance, or any  
18 combination of these coverages, shall provide that an employee  
19 or member whose insurance under the group policy has been  
20 terminated for any reason, including discontinuance of the  
21 group policy in its entirety or with respect to an insured  
22 class, and who has been continuously insured under the group  
23 policy, and under any group policy providing similar benefits  
24 that the terminated group policy replaced, for at least 3  
25 months immediately prior to termination, shall be entitled to  
26 have issued to him by the insurer a policy or certificate of  
27 health insurance, referred to in this section as a "converted  
28 policy." An employee or member shall not be entitled to a  
29 converted policy if termination of his insurance under the  
30 group policy occurred because he failed to pay any required  
31 contribution, or because any discontinued group coverage was

1 replaced by similar group coverage within 31 days after  
2 discontinuance.

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

7 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR  
8 GROUP COVERAGE.--

9 (a) The premium for the converted policy shall be  
10 determined in accordance with premium rates applicable to the  
11 age and class of risk of each person to be covered under the  
12 converted policy and to the type and amount of insurance  
13 provided. However, the premium for the converted policy may  
14 not exceed 200 percent of the standard risk rate as  
15 established by the Florida Comprehensive Health Association,  
16 adjusted for differences in benefit levels and structure  
17 between the converted policy and the policy offered by the  
18 Florida Comprehensive Health Association.

19 (11) ALTERNATIVE PLANS.--The insurer shall, in  
20 addition to the option required by subsection (10), offer the  
21 standard health benefit plan, as established pursuant to s.  
22 627.6699(12).The insurer may, at its option, also offer  
23 alternative plans for group health conversion in addition to  
24 the plans ~~one~~ required by this section.

25 Section 14. (1) The changes made by this act to  
26 section 627.6675, Florida Statutes, apply to conversion  
27 policies offered, sold, issued, or renewed on or after January  
28 1, 1998.

29 (2) An individual who was entitled on July 1, 1997, to  
30 a conversion policy under section 627.6675, Florida Statutes,  
31 shall be entitled on January 1, 1998, to a conversion policy

1 meeting the requirements of section 627.6675, Florida  
2 Statutes, as amended by this act. Such an individual shall  
3 remain entitled to a conversion policy for the same period of  
4 time after January 1, 1998, as the individual would have  
5 remained eligible after July 1, 1997, including the condition  
6 that application for coverage be made within 63 days of the  
7 termination of the group coverage.

8           Section 15. Subsections (3), (5), and (7), and  
9 paragraph (b) of subsection (11) of section 627.6699, Florida  
10 Statutes, 1996 Supplement, are amended, and present  
11 subsections (14) and (15) of that section are redesignated as  
12 subsections (15) and (16), respectively, and a new subsection  
13 (14) is added to that section, to read:

14           627.6699 Employee Health Care Access Act.--

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

16           (a) "Actuarial certification" means a written  
17 statement, by a member of the American Academy of Actuaries or  
18 another person acceptable to the department, that a small  
19 employer carrier is in compliance with subsection (6), based  
20 upon the person's examination, including a review of the  
21 appropriate records and of the actuarial assumptions and  
22 methods used by the carrier in establishing premium rates for  
23 applicable health benefit plans.

24           (b) "Basic health benefit plan" and "standard health  
25 benefit plan" mean low-cost health care plans developed  
26 pursuant to subsection (12).

27           (c) "Board" means the board of directors of the  
28 program.

29           (d) "Carrier" means a person who provides health  
30 benefit plans in this state, including an authorized insurer,  
31 a health maintenance organization, a multiple-employer welfare

1 arrangement, or any other person providing a health benefit  
 2 plan that is subject to insurance regulation in this state.  
 3 However, the term does not include a multiple-employer welfare  
 4 arrangement, which multiple-employer welfare arrangement  
 5 operates solely for the benefit of the members or the members  
 6 and the employees of such members, and was in existence on  
 7 January 1, 1992.

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

12 (f) "Creditable coverage" has the same meaning  
 13 ascribed in s. 627.6561.

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

17 (h)~~(g)~~ "Eligible employee" means an employee who works  
 18 full time, having a normal workweek of 25 or more hours, and  
 19 who has met any applicable waiting-period requirements or  
 20 other requirements of this act. The term includes a  
 21 self-employed individual, a sole proprietor, a partner of a  
 22 partnership, or an independent contractor, if the sole  
 23 proprietor, partner, or independent contractor is included as  
 24 an employee under a health benefit plan of a small employer,  
 25 but does not include a part-time, temporary, or substitute  
 26 employee.

27 (i)~~(h)~~ "Established geographic area" means the county  
 28 or counties, or any portion of a county or counties, within  
 29 which the carrier provides or arranges for health care  
 30 services to be available to its insureds, members, or  
 31 subscribers.

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

5        (k)~~(j)~~ "Health benefit plan" means any hospital or  
6 medical policy or certificate, hospital or medical service  
7 plan contract, or health maintenance organization subscriber  
8 contract. The term does not include accident-only, specified  
9 disease, individual hospital indemnity, credit, dental-only,  
10 vision-only, Medicare supplement, long-term care, or  
11 disability income insurance; coverage issued as a supplement  
12 to liability insurance; workers' compensation or similar  
13 insurance; or automobile medical-payment insurance.

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

20            1. ~~Was covered under another employer health benefit~~  
21 ~~plan at the time the individual was eligible to enroll; lost~~  
22 ~~coverage under that plan as a result of termination of~~  
23 ~~employment, the termination of the other plan's coverage, the~~  
24 ~~death of a spouse, or divorce; and requests enrollment within~~  
25 ~~30 days after coverage under that plan was terminated;~~

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

29            3. ~~A court has ordered that coverage be provided for a~~  
30 ~~spouse or minor child under a covered employee's health~~

31

1 ~~benefit plan and a request for enrollment is made within 30~~  
2 ~~days after issuance of the court order.~~

3 (m)~~(l)~~ "Limited benefit policy or contract" means a  
4 policy or contract that provides coverage for each person  
5 insured under the policy for a specifically named disease or  
6 diseases, a specifically named accident, or a specifically  
7 named limited market that fulfills an experimental or  
8 reasonable need, such as the small group market.

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

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

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

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

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

31

1           ~~2. Pregnancy existing on the effective date of~~  
2 ~~coverage.~~

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

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

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

10           ~~2. An individual health insurance policy, including~~  
11 ~~coverage issued by a health maintenance organization, a~~  
12 ~~fraternal benefit society, or a multiple-employer welfare~~  
13 ~~arrangement, that provides benefits similar to or exceeding~~  
14 ~~the benefits provided under the basic health benefit plan,~~  
15 ~~provided that such policy has been in effect for a period of~~  
16 ~~at least 1 year.~~

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

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

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

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

1           (v)~~(w)~~ "Small employer" means, in connection with a  
 2 health benefit plan with respect to a calendar year and a plan  
 3 year, any person, sole proprietor, self-employed individual,  
 4 independent contractor, firm, corporation, partnership, or  
 5 association that is actively engaged in business, has its  
 6 principal place of business in this state, and that, on at  
 7 least 50 percent of its working days during the preceding  
 8 calendar quarter, employed an average of at least one but not  
 9 more than 50 eligible employees on business days during the  
 10 preceding calendar year, and employed at least one employee on  
 11 the first day of the plan year, the majority of whom were  
 12 employed within this state. In determining the number of  
 13 eligible employees, companies that are affiliated companies,  
 14 or that are eligible to file a combined tax return for  
 15 purposes of state taxation, may be considered a single  
 16 employer. For purposes of this section, a sole proprietor, an  
 17 independent contractor, or a self-employed individual is  
 18 considered a small employer only if all of the conditions and  
 19 criteria established in this section are met.

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

23           (5) AVAILABILITY OF COVERAGE.--

24           (a) Beginning January 1, 1993, every small employer  
 25 carrier issuing new health benefit plans to small employers in  
 26 this state must, as a condition of transacting business in  
 27 this state, offer to eligible small employers a standard  
 28 health benefit plan and a basic health benefit plan. Such a  
 29 small employer carrier shall issue a standard health benefit  
 30 plan or a basic health benefit plan to every eligible small  
 31 employer that elects to be covered under such plan, agrees to



1 make the required premium payments under such plan, and to  
2 satisfy the other provisions of the plan.

3 (b) In the case of a small employer carrier which does  
4 not, on or after January 1, 1993, offer coverage but which  
5 does, on or after January 1, 1993, renew or continue coverage  
6 in force, such carrier shall be required to provide coverage  
7 to newly eligible employees and dependents on the same basis  
8 as small employer carriers which are offering coverage on or  
9 after January 1, 1993.

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

12 1. Beginning January 1, 1994, offer and issue all  
13 small employer health benefit plans on a guaranteed-issue  
14 basis to every eligible small employer, with 3 to 50 eligible  
15 employees, that elects to be covered under such plan, agrees  
16 to make the required premium payments, and satisfies the other  
17 provisions of the plan. A rider for additional or increased  
18 benefits may be medically underwritten and may only be added  
19 to the standard health benefit plan. The increased rate  
20 charged for the additional or increased benefit must be rated  
21 in accordance with this section.

22 2. Beginning April 15, 1994, offer and issue basic and  
23 standard small employer health benefit plans on a  
24 guaranteed-issue basis to every eligible small employer, with  
25 one or two eligible employees, which elects to be covered  
26 under such plan, agrees to make the required premium payments,  
27 and satisfies the other provisions of the plan. A rider for  
28 additional or increased benefits may be medically underwritten  
29 and may only be added to the standard health benefit plan.  
30 The increased rate charged for the additional or increased  
31 benefit must be rated in accordance with this section.

1           3. Offer to eligible small employers the standard and  
2 basic health benefit plans. This subparagraph does not limit  
3 a carrier's ability to offer other health benefit plans to  
4 small employers if the standard and basic health benefit plans  
5 are offered and rejected.

6           (d) A small employer carrier must file with the  
7 department, in a format and manner prescribed by the  
8 committee, a standard health care plan and a basic health care  
9 plan to be used by the carrier.

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

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

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

23           2. ~~Preexisting condition provisions may relate only~~  
24 ~~to:~~

25           a. ~~Conditions that, during the 6-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           (g) A health benefit plan covering small employers,  
4 issued or renewed on or after January 1, 1994, must comply  
5 with the following conditions:

6           1. All health benefit plans must be offered and issued  
7 on a guaranteed-issue basis, except that benefits purchased  
8 through riders as provided in paragraph (c) may be medically  
9 underwritten for the group, but may not be individually  
10 underwritten as to the employees or the dependents of such  
11 employees. Additional or increased benefits may only be  
12 offered by riders.

13           2. The provisions of paragraph (f) apply to health  
14 benefit plans issued to a small employer who has two ~~three~~ or  
15 more eligible employees, and to health benefit plans that are  
16 issued to a small employer who has fewer than two ~~three~~  
17 eligible employees and that cover an employee who has had  
18 creditable ~~qualifying previous~~ coverage continually to a date  
19 not more than 63 ~~30~~ days before the effective date of the new  
20 coverage.

21           ~~3. With respect to any employee or dependent excluded~~  
22 ~~from coverage due to disease or medical condition or whose~~  
23 ~~coverage had been restricted for certain diseases or medical~~  
24 ~~conditions prior to January 1, 1993, and who has continued to~~  
25 ~~be an eligible employee or dependent as of April 1, 1993, an~~  
26 ~~open enrollment period shall be provided for a 90-day period~~  
27 ~~beginning within 60 days following the effective date of this~~  
28 ~~act, during which period any such employee or dependent shall~~  
29 ~~be entitled to be included within coverage and/or issued~~  
30 ~~coverage without restrictions for certain diseases or medical~~  
31 ~~conditions.~~

1           3.4. For health benefit plans that are issued to a  
2 small employer who has fewer than two ~~three~~ employees and that  
3 cover an employee who has not been continually covered by  
4 creditable ~~qualifying previous~~ coverage within 63 ~~30~~ days  
5 before the effective date of the new coverage, preexisting  
6 condition provisions must not exclude coverage for a period  
7 beyond 24 months following the employee's effective date of  
8 coverage and may relate only to:

9           a. Conditions that, during the 24-month period  
10 immediately preceding the effective date of coverage, had  
11 manifested themselves in such a manner as would cause an  
12 ordinarily prudent person to seek medical advice, diagnosis,  
13 care, or treatment or for which medical advice, diagnosis,  
14 care, or treatment was recommended or received; or

15           b. A pregnancy existing on the effective date of  
16 coverage.

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

19           1. ~~In determining whether a preexisting condition~~  
20 ~~provision applies to an eligible employee or dependent, credit~~  
21 ~~must be given for the time the person was covered under~~  
22 ~~qualifying previous coverage if the previous coverage was~~  
23 ~~continuous to a date not more than 30 days prior to the~~  
24 ~~effective date of the new coverage, exclusive of any~~  
25 ~~applicable waiting period under the plan.~~

26           2. ~~Late enrollees may be excluded from coverage only~~  
27 ~~for the greater of 18 months or the period of an 18-month~~  
28 ~~preexisting condition exclusion; however, if both a period of~~  
29 ~~exclusion from coverage and a preexisting condition exclusion~~  
30 ~~are applicable to a late enrollee, the combined period may not~~  
31 ~~exceed 18 months after the effective date of coverage. For~~

1 employers who have fewer than two ~~three~~ employees, a late  
 2 enrollee may be excluded from coverage for no longer than 24  
 3 months if he was not covered by creditable ~~qualifying previous~~  
 4 coverage continually to a date not more than 63 ~~30~~ days before  
 5 the effective date of his new coverage.

6 ~~2.3.~~ Any requirement used by a small employer carrier  
 7 in determining whether to provide coverage to a small employer  
 8 group, including requirements for minimum participation of  
 9 eligible employees and minimum employer contributions, must be  
 10 applied uniformly among all small employer groups having the  
 11 same number of eligible employees applying for coverage or  
 12 receiving coverage from the small employer carrier. A small  
 13 employer carrier may vary application of minimum participation  
 14 requirements and minimum employer contribution requirements  
 15 only by the size of the small employer group.

16 ~~3.4.~~ In applying minimum participation requirements  
 17 with respect to a small employer, a small employer carrier  
 18 shall not consider as an eligible employee employees or  
 19 dependents who have qualifying existing coverage in an  
 20 employer-based group insurance plan or an ERISA qualified  
 21 self-insurance plan in determining whether the applicable  
 22 percentage of participation is met. However, a small employer  
 23 carrier may count eligible employees and dependents who have  
 24 coverage under another health plan that is sponsored by that  
 25 employer except if such plan is offered pursuant to s.  
 26 408.706.

27 ~~4.5.~~ A small employer carrier shall not increase any  
 28 requirement for minimum employee participation or any  
 29 requirement for minimum employer contribution applicable to a  
 30 small employer at any time after the small employer has been  
 31 accepted for coverage, unless the employer size has changed,

1 in which case the small employer carrier may apply the  
2 requirements that are applicable to the new group size.

3 ~~5.6.~~ If a small employer carrier offers coverage to a  
4 small employer, it must offer coverage to all the small  
5 employer's eligible employees and their dependents. A small  
6 employer carrier may not offer coverage limited to certain  
7 persons in a group or to part of a group, except with respect  
8 to late enrollees.

9 ~~6.7.~~ A small employer carrier may not modify any  
10 health benefit plan issued to a small employer with respect to  
11 a small employer or any eligible employee or dependent through  
12 riders, endorsements, or otherwise to restrict or exclude  
13 coverage for certain diseases or medical conditions otherwise  
14 covered by the health benefit plan.

15 ~~7.8.~~ An initial enrollment period of at least 30 days  
16 must be provided. An annual 30-day open enrollment period  
17 must be offered to each small employer's eligible employees  
18 and their dependents. A small employer carrier must provide  
19 special enrollment periods as required by s. 627.65615.

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

22 a. To a small employer if the small employer is not  
23 physically located in an established geographic service area  
24 of the small employer carrier, provided such geographic  
25 service area shall not be less than a county;

26 b. To an employee if the employee does not work or  
27 reside within an established geographic service area of the  
28 small employer carrier; or

29 c. To a small employer group within an area in which  
30 the small employer carrier reasonably anticipates, and  
31 demonstrates to the satisfaction of the department, that it

1 cannot, within its network of providers, deliver service  
2 adequately to the members of such groups because of  
3 obligations to existing group contract holders and enrollees.

4 2. A small employer carrier that cannot offer coverage  
5 pursuant to sub-subparagraph 1.c. may not offer coverage in  
6 the applicable area to new cases of employer groups having  
7 more than 50 eligible employees or small employer groups until  
8 the later of 180 days following each such refusal or the date  
9 on which the carrier notifies the department that it has  
10 regained its ability to deliver services to small employer  
11 groups.

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

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

17 (II) It is applying this sub-subparagraph uniformly to  
18 all employers in the small-group market in this state  
19 consistent with this section and without regard to the claims  
20 experience of those employers and their employees and their  
21 dependents or any health-status-related factor that relates to  
22 such employees and dependents.

23 b. A small employer carrier, upon denying health  
24 insurance coverage in connection with health benefit plans in  
25 accordance with sub-subparagraph a., may not offer coverage in  
26 connection with group health benefit plans in the small-group  
27 market in this state for a period of 180 days after the date  
28 such coverage is denied or until the insurer has demonstrated  
29 to the department that the insurer has sufficient financial  
30 reserves to underwrite additional coverage, whichever is  
31 later. The department may provide for the application of this

1 sub-subparagraph on a service-area-specific basis.The  
2 ~~department shall, by rule, require each small employer carrier~~  
3 ~~to report, along with its annual statement for calendar year~~  
4 ~~1992, its gross annual premiums for health benefit plans~~  
5 ~~issued to small employers during calendar year 1992, including~~  
6 ~~both new and renewal business. No later than May 1, 1993, the~~  
7 ~~department shall calculate each carrier's percentage of all~~  
8 ~~small employer carrier premiums for calendar year 1992.~~

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

12           ~~(I) After its gross annual premiums for all small~~  
13 ~~employer group health benefit plans written or renewed for~~  
14 ~~that year, excluding blocks of business assumed from other~~  
15 ~~carriers, exceeds 25 percent of the total of all small~~  
16 ~~employer carrier premiums for calendar year 1992; or~~

17           ~~(II) After its gross annual premiums for small~~  
18 ~~employer group health benefit plans written or renewed for~~  
19 ~~that year, excluding blocks of business assumed from other~~  
20 ~~carriers, exceeds three times that carrier's gross annual~~  
21 ~~premiums for small employer group health benefit plans written~~  
22 ~~or renewed during calendar year 1992, if its share of small~~  
23 ~~employer carrier business for calendar year 1992 calculated~~  
24 ~~under sub-subparagraph a. exceeds 2 percent.~~

25       ~~c. The election under sub-subparagraph b. is effective~~  
26 ~~upon filing of a notice of election with the department. The~~  
27 ~~department may, within 30 days after the filing of the notice,~~  
28 ~~disapprove the election if it finds that the carrier does not~~  
29 ~~meet the criteria of sub-subparagraph b. If the department~~  
30 ~~disapproves the election, the carrier is subject to paragraph~~  
31 ~~(a), effective on the date of such disapproval.~~



1 ~~d. An election under sub-subparagraph b. expires on~~  
2 ~~December 31, 1993, or upon revocation, whichever occurs~~  
3 ~~earlier.~~

4 ~~e. A carrier may file with the department a notice~~  
5 ~~revoking its election under sub-subparagraph b. after the~~  
6 ~~election has been in effect for at least 3 months. Such~~  
7 ~~revocation of an election takes effect on the first day of the~~  
8 ~~calendar quarter following the filing of such notice with the~~  
9 ~~department and subjects the carrier to all requirements of~~  
10 ~~paragraph (a).~~

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

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

16 4.a. Beginning in 1994, the department shall, by rule,  
17 require each small employer carrier to report, on or before  
18 March 1 of each year, its gross annual premiums for all health  
19 benefit plans issued to small employers during the previous  
20 calendar year, and also to report its gross annual premiums  
21 for new, but not renewal, standard and basic health benefit  
22 plans subject to this section issued during the previous  
23 calendar year. No later than May 1 of each year, the  
24 department shall calculate each carrier's percentage of all  
25 small employer group health premiums for the previous calendar  
26 year and shall calculate the aggregate gross annual premiums  
27 for new, but not renewal, standard and basic health benefit  
28 plans for the previous calendar year.

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

1           ~~(I) After its gross annual premiums for new, but not~~  
2 ~~renewal, health benefit plans subject to this section for that~~  
3 ~~year, excluding blocks of business assumed from other~~  
4 ~~carriers, exceeds 25 percent of the aggregate gross annual~~  
5 ~~premiums for new, but not renewal, health benefit plans~~  
6 ~~subject to this section for the previous calendar year as~~  
7 ~~determined under sub-subparagraph a.; or~~

8           ~~(II) After its gross annual premiums for new, but not~~  
9 ~~renewal, health benefit plans subject to this section,~~  
10 ~~excluding blocks of business assumed from other carriers,~~  
11 ~~exceeds three times the carrier's percentage of all small~~  
12 ~~employer group premiums for the previous calendar year as~~  
13 ~~determined under sub-subparagraph a., multiplied by the~~  
14 ~~aggregate gross annual premiums for new health benefit plans~~  
15 ~~for the previous year as determined under sub-subparagraph a.~~  
16 ~~A carrier may not exercise this option unless its percentage~~  
17 ~~of all small employer group premiums for the previous calendar~~  
18 ~~year as determined under sub-subparagraph a. exceeds 2~~  
19 ~~percent.~~

20           ~~c. The election under sub-subparagraph b. is effective~~  
21 ~~upon filing of a notice of election with the department. The~~  
22 ~~department may, within 30 days after the filing of the notice,~~  
23 ~~disapprove the election if it finds that the carrier does not~~  
24 ~~meet the criteria of sub-subparagraph b. If the department~~  
25 ~~disapproves the election, the carrier is subject to paragraph~~  
26 ~~(a), effective on the date of such disapproval.~~

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

30           ~~e. A carrier may file with the department a notice~~  
31 ~~revoking its election under sub-subparagraph b. after the~~

1 ~~election has been in effect for at least 3 months. Such~~  
2 ~~revocation of an election takes effect on the first day of the~~  
3 ~~calendar quarter following the filing of such notice with the~~  
4 ~~department and subjects the carrier to all requirements of~~  
5 ~~paragraph (a).~~

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

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

12 ~~(j) A small employer carrier may not offer coverage or~~  
13 ~~accept applications pursuant to paragraph (a) if the~~  
14 ~~department finds that the acceptance of an application or~~  
15 ~~applications would endanger the financial condition of the~~  
16 ~~small employer carrier or endanger the interests of the small~~  
17 ~~employer carrier's insureds.~~

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

22 (7) RENEWABILITY OF COVERAGE. ~~Except as provided in~~  
23 ~~paragraph (b),~~ A health benefit plan that is subject to this  
24 section is renewable for all eligible employees and dependents  
25 pursuant to s. 627.6571. at the option of the small employer,  
26 except for any of the following reasons:

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

28 ~~(b) Fraud or misrepresentation by the small employer~~  
29 ~~or fraud or misrepresentation by the insured individual or~~  
30 ~~subscriber or the individual's or subscriber's representative;~~

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

1           ~~(d) Noncompliance with the carrier's minimum~~  
2 ~~participation requirements;~~

3           ~~(e) Noncompliance with the carrier's employer~~  
4 ~~contribution requirements;~~

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

7           ~~(g) A determination by the department that the~~  
8 ~~continuation of the coverage is not in the best interest of~~  
9 ~~the policyholders or certificateholders or will impair the~~  
10 ~~carrier's ability to meet its contractual obligations. In~~  
11 ~~such instances, the department must assist affected small~~  
12 ~~employers in finding replacement coverage.~~

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

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

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

20           a. One member shall be a representative of the largest  
21 health insurer in the state, as determined by market share as  
22 of December 31, 1991.

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

26           c. Three members shall be selected from a list of  
27 individuals recommended by the Health Insurance Association of  
28 America.

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

31

1 The terms of members appointed under this subparagraph expire  
2 on December 31, 1993. The appointment of a member under this  
3 subparagraph does not preclude the commissioner from  
4 appointing the same person to serve as a member under  
5 subparagraph 3.

6 3. Beginning January 1, 1994, the board shall consist  
7 of the commissioner or his designee, who shall serve as  
8 chairman, and eight additional members who are representatives  
9 of carriers and are appointed by the commissioner. ~~and serve~~  
10 ~~as follows:~~

11 4. Effective upon this act becoming a law, the board  
12 shall consist of the commissioner or his or her designee, who  
13 shall serve as the chairperson, and 13 additional members who  
14 are representatives of carriers and insurance agents and are  
15 appointed by the commissioner and serve as follows:

16 a. The commissioner shall include representatives of  
17 small employer carriers subject to assessment under this  
18 subsection. If two or more carriers elect to be risk-assuming  
19 carriers, the membership must include at least two  
20 representatives of risk-assuming carriers; if one carrier is  
21 risk-assuming, one member must be a representative of such  
22 carrier. At least one member must be a carrier who is subject  
23 to the assessments, but is not a small employer carrier.  
24 Subject to such restrictions, at least five members shall be  
25 selected from individuals recommended by small employer  
26 carriers pursuant to procedures provided by rule of the  
27 department. Three members shall be selected from a list of  
28 health insurance carriers that issue individual health  
29 insurance policies. At least two of the three members selected  
30 must be reinsuring carriers. Two members shall be selected  
31

1 from a list of insurance agents who are actively engaged in  
2 the sale of health insurance.

3         b. A member appointed under this subparagraph shall  
4 serve a term of 4 years and shall continue in office until the  
5 member's successor takes office, except that, in order to  
6 provide for staggered terms, the commissioner shall designate  
7 two of the initial appointees under this subparagraph to serve  
8 terms of 2 years and shall designate three of the initial  
9 appointees under this subparagraph to serve terms of 3 years.

10         ~~5.4.~~ The commissioner may remove a member for cause.

11         ~~6.5.~~ Vacancies on the board shall be filled in the  
12 same manner as the original appointment for the unexpired  
13 portion of the term.

14         ~~7.6.~~ The commissioner may require an entity that  
15 recommends persons for appointment to submit additional lists  
16 of recommended appointees.

17         (14) DISCLOSURE OF INFORMATION.--

18         (a) In connection with the offering of a health  
19 benefit plan to a small employer, a small employer carrier  
20 shall:

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

24             2. Upon request of the small employer, provide such  
25 information.

26         (b)1. Subject to subparagraph 3., with respect to a  
27 small employer carrier that offers a health benefit plan to a  
28 small employer, information described in this paragraph is  
29 information that concerns:

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

4           b. The provisions of such coverage that relate to  
5 renewability of coverage;

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

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

10           2. Information required under this subsection shall be  
11 provided to small employers in a manner determined to be  
12 understandable by the average small employer, and shall be  
13 sufficient to reasonably inform small employers of their  
14 rights and obligations under the health insurance coverage.

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

18           Section 16. Section 627.9404, Florida Statutes, 1996  
19 Supplement, is amended to read:

20           627.9404 Definitions.--For the purposes of this part:

21           (1) "Long-term care insurance" means any insurance  
22 policy or rider advertised, marketed, offered, or designed to  
23 provide coverage on an expense-incurred, indemnity, prepaid,  
24 or other basis for one or more necessary or medically  
25 necessary diagnostic, preventive, therapeutic, curing,  
26 treating, mitigating, rehabilitative, maintenance, or personal  
27 care services provided in a setting other than an acute care  
28 unit of a hospital. Long-term care insurance shall not  
29 include any insurance policy which is offered primarily to  
30 provide basic Medicare supplement coverage, basic hospital  
31 expense coverage, basic medical-surgical expense coverage,

1 hospital confinement indemnity coverage, major medical expense  
2 coverage, disability income protection coverage, accident only  
3 coverage, specified disease or specified accident coverage, or  
4 limited benefit health coverage.

5 (2) "Applicant" means:

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

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

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

14 (4) "Chronically ill" means certified, within the  
15 preceding 12-month period, by a licensed health care  
16 practitioner as:

17 (a) Being unable to perform, without substantial  
18 assistance from another individual, at least two activities of  
19 daily living for a period of at least 90 days due to a loss of  
20 functional capacity;

21 (b) Having a level of disability similar to the level  
22 of disability described in paragraph (a); or

23 (c) Requiring substantial supervision for protection  
24 from threats to health and safety due to severe cognitive  
25 impairment.

26 (5)~~(4)~~ "Cognitive impairment" means a deficiency in a  
27 person's short-term or long-term memory, orientation as to  
28 person, place, and time, deductive or abstract reasoning, or  
29 judgment as it relates to safety awareness.

30 (6) "Licensed health care practitioner" means any  
31 physician, nurse licensed under chapter 464, or



1 psychotherapist licensed under chapter 490 or chapter 491, or  
2 any individual who meets any requirements prescribed by rule  
3 by the Insurance Commissioner.

4 (7) "Maintenance or personal care services" means any  
5 care the primary purpose of which is the provision of needed  
6 assistance with any of the disabilities as a result of which  
7 the individual is a chronically ill individual, including the  
8 protection from threats to health and safety due to severe  
9 cognitive impairment.

10 (8)(5) "Policy" means any policy, contract, subscriber  
11 agreement, rider, or endorsement delivered or issued for  
12 delivery in this state by any of the entities specified in s.  
13 627.9403.

14 (9) "Qualified long-term care services" means  
15 necessary diagnostic, preventive, curing, treating,  
16 mitigating, and rehabilitative services, and maintenance or  
17 personal care services which are required by a chronically ill  
18 individual and are provided pursuant to a plan of care  
19 prescribed by a licensed health care practitioner.

20 (10) "Qualified long-term care insurance policy" means  
21 an accident and health insurance contract as defined in s.  
22 7702B of the Internal Revenue Code.

23 Section 17. Subsection (1) of section 627.9407,  
24 Florida Statutes, is amended, and subsection (12) is added to  
25 said section, to read:

26 627.9407 Disclosure, advertising, and performance  
27 standards for long-term care insurance.--

28 (1) STANDARDS.--The department shall adopt rules that  
29 include standards for full and fair disclosure setting forth  
30 the manner, content, and required disclosures of the sale of  
31 long-term care insurance policies, terms of renewability,

1 initial and subsequent conditions of eligibility,  
2 nonduplication of coverage provisions, coverage of dependents,  
3 preexisting conditions, termination of insurance, continuation  
4 or conversion, probationary periods, limitations, exceptions,  
5 reductions, elimination periods, requirements for replacement,  
6 recurrent conditions, disclosure of tax consequences, benefit  
7 triggers, prohibition against post-claims underwriting,  
8 reporting requirements, standards for marketing, and  
9 definitions of terms.

10 (12) DISCLOSURE.--A qualified long-term care insurance  
11 policy must include a disclosure statement within the policy  
12 and within the outline of coverage that the policy is intended  
13 to be a qualified long-term contract. A long-term care  
14 insurance policy that is not intended to be a qualified  
15 long-term care insurance contract must include a disclosure  
16 statement within the policy and within the outline of coverage  
17 that the policy is not intended to be a qualified long-term  
18 care insurance contract. The disclosure shall be prominently  
19 displayed and shall read as follows: "This long-term care  
20 insurance policy is not intended to be a qualified long-term  
21 care insurance contract. You need to be aware that benefits  
22 received under this policy may create unintended, adverse  
23 income tax consequences to you. You may want to consult with a  
24 knowledgeable individual about such potential income tax  
25 consequences."

26 Section 18. Subsections (6), (7), (8), (9), and (10)  
27 are added to section 627.94071, Florida Statutes, 1996  
28 Supplement, to read:

29 627.94071 Minimum standards for home health care  
30 benefits.--A long-term care insurance policy, certificate, or  
31 rider that contains a home health care benefit must meet or

1 exceed the minimum standards specified in this section. The  
2 policy, certificate, or rider may not exclude benefits by any  
3 of the following means:

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

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

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

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

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

14 Section 19. Subsection (2) of section 627.94072,  
15 Florida Statutes, 1996 Supplement, is amended to read:

16 627.94072 Mandatory offers.--

17 (2) An insurer that offers a long-term care insurance  
18 policy, certificate, or rider in this state must offer a  
19 nonforfeiture protection provision providing reduced paid-up  
20 insurance, ~~cash surrender values which may include return of~~  
21 ~~premiums~~, extended term, shortened benefit period, or any  
22 other benefits approved by the department if all or part of a  
23 premium is not paid. Nonforfeiture benefits and any  
24 additional premium for such benefits must be computed in an  
25 actuarially sound manner, using a methodology that has been  
26 filed with and approved by the department.

27 Section 20. Section 627.94073, Florida Statutes, 1996  
28 Supplement, is amended to read:

29 627.94073 Notice of cancellation; grace period.--

30 (1) A long-term care policy shall provide that the  
31 insured is entitled to a grace period of not less than 30

1 days, within which payment of any premium after the first may  
2 be made. The insurer may require payment of an interest  
3 charge not in excess of 8 percent per year for the number of  
4 days elapsing before the payment of the premium, during which  
5 period the policy shall continue in force. If the policy  
6 becomes a claim during the grace period before the overdue  
7 premium is paid, the amount of such premium or premiums with  
8 interest not in excess of 8 percent per year may be deducted  
9 in any settlement under the policy.

10 (2) A long-term care policy may not be canceled for  
11 nonpayment of premium unless, after expiration of the grace  
12 period in subsection (1), and at least 30 days prior to the  
13 effective date of such cancellation, the insurer has mailed a  
14 notification of possible lapse in coverage to the policyholder  
15 and to a specified secondary addressee if such addressee has  
16 been designated in writing by name and address by the  
17 policyholder. For policies issued or renewed on or after  
18 October 1, 1996, the insurer shall notify the policyholder, at  
19 least once every 2 years, of the right to designate a  
20 secondary addressee. The applicant has the right to designate  
21 at least one person who is to receive the notice of  
22 termination, in addition to the insured. Designation shall not  
23 constitute acceptance of any liability on the third party for  
24 services provided to the insured. The form used for the  
25 written designation must provide space clearly designated for  
26 listing at least one person. The designation shall include  
27 each person's full name and home address. In the case of an  
28 applicant who elects not to designate an additional person,  
29 the waiver shall state: "Protection against unintended  
30 lapse.--I understand that I have the right to designate at  
31 least one person other than myself to receive notice of lapse

1 or termination of this long-term care insurance policy for  
 2 nonpayment of premium. I understand that notice will not be  
 3 given until 30 days after a premium is due and unpaid. I elect  
 4 NOT to designate any person to receive such notice." Notice  
 5 shall be given by first class United States mail, postage  
 6 prepaid, and notice may not be given until 30 days after a  
 7 premium is due and unpaid. Notice shall be deemed to have been  
 8 given as of 5 days after the date of mailing.

9 (3) If a policy is canceled due to nonpayment of  
 10 premium, the policyholder shall be entitled to have the policy  
 11 reinstated if, within a period of not less than 5 months ~~150~~  
 12 ~~days~~ after the date of cancellation, the policyholder or any  
 13 secondary addressee designated pursuant to subsection (2)  
 14 demonstrates that the failure to pay the premium when due was  
 15 unintentional and due to the cognitive impairment or loss of  
 16 functional capacity of the policyholder. Policy reinstatement  
 17 shall be subject to payment of overdue premiums. The standard  
 18 of proof of cognitive impairment or loss of functional  
 19 capacity shall not be more stringent than the benefit  
 20 eligibility criteria for cognitive impairment or the loss of  
 21 functional capacity, if any, contained in the policy and  
 22 certificate.The insurer may require payment of an interest  
 23 charge not in excess of 8 percent per year for the number of  
 24 days elapsing before the payment of the premium, during which  
 25 period the policy shall continue in force if the demonstration  
 26 of cognitive impairment is made. If the policy becomes a  
 27 claim during the 180-day period before the overdue premium is  
 28 paid, the amount of the premium or premiums with interest not  
 29 in excess of 8 percent per year may be deducted in any  
 30 settlement under the policy.

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

9           Section 21. Section 627.94074, Florida Statutes, 1996  
10 Supplement, is amended to read:

11           627.94074 Standards for benefit triggers.--

12           (1)(a) A long-term care insurance policy shall  
13 condition the payment of benefits on a determination of the  
14 insured's ability to perform activities of daily living and on  
15 cognitive impairment. Eligibility for the payment of benefits  
16 shall not be more restrictive than requiring either a  
17 deficiency in the ability to perform not more than three of  
18 the activities of daily living or the presence of cognitive  
19 impairment; ~~or-~~

20           (b) If a policy is a qualified long-term care  
21 insurance policy, the policy shall condition the payment of  
22 benefits on a determination of the insured as being  
23 chronically ill; having a level of disability similar, as  
24 provided by rule of the Insurance Commissioner, to the  
25 insured's ability to perform activities of daily living; or  
26 being cognitively impaired as described in paragraph (6)(b).  
27 Eligibility for the payment of benefits shall not be more  
28 restrictive than requiring a deficiency in the ability to  
29 perform not more than three of the activities of daily living.

30           (2) Activities of daily living shall include at least:  
31

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

4 (b) "Continence," which means the ability to maintain  
5 control of bowel and bladder function, or, when unable to  
6 maintain control of bowel or bladder function, the ability to  
7 perform associated personal hygiene, including caring for  
8 catheter or colostomy bag.

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

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

15 (e) "Toileting," which means getting to and from the  
16 toilet, getting on and off the toilet, and performing  
17 associated personal hygiene.

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

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

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

26 (5)(4) An insurer may use additional provisions, for a  
27 policy described in paragraph (1)(a), for the determination of  
28 when benefits are payable under a policy or certificate;  
29 however, the provisions shall not restrict and are not in lieu  
30 of, the requirements contained in subsections (1) and (2).

31

1           ~~(6)(5)~~ For purposes of this section, the determination  
2 of a deficiency due to loss of functional capacity or  
3 cognitive impairment shall not be more restrictive than:

4           (a) Requiring the hands-on assistance of another  
5 person to perform the prescribed activities of daily living,  
6 meaning physical assistance, minimal, moderate, or maximal,  
7 without which the individual would not be able to perform the  
8 activity of daily living; or

9           (b) ~~If the deficiency is~~ Due to the presence of a  
10 cognitive impairment, requiring supervision, including or  
11 verbal cueing by another person ~~is needed~~ in order to protect  
12 the insured or others.

13           ~~(7)(6)~~ Assessment of activities of daily living and  
14 cognitive impairment shall be performed by licensed or  
15 certified professionals, such as physicians, nurses, or social  
16 workers.

17           ~~(8)(7)~~ Long-term care insurance policies shall include  
18 a clear description of the process for appealing and resolving  
19 the benefit determinations.

20           ~~(9)(8)~~ The requirement set forth in this section shall  
21 be effective on July 1, 1997, and shall apply as follows:

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

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

28           Section 22. Section 641.2018, Florida Statutes, is  
29 created to read:

30           641.2018 High-deductible contracts for medical savings  
31 accounts.--Notwithstanding the provisions of this part and



1 part III related to the requirement for providing  
2 comprehensive coverage, a health maintenance organization may  
3 offer a high-deductible contract to employers that establish  
4 medical savings accounts, as defined in section 220(d) of the  
5 Internal Revenue Code.

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

8 641.31 Health maintenance contracts.--

9 (18)(a) Health maintenance contracts that ~~which~~  
10 provide coverage, benefits, or services for maternity care  
11 must ~~shall~~ provide, as an option to the subscriber, the  
12 services of nurse-midwives and midwives licensed pursuant to  
13 chapter 467, and the services of birth centers licensed  
14 pursuant to ss. 383.30-383.335, if such services are available  
15 within the service area.

16 (b) Any health maintenance contract that ~~which~~  
17 provides maternity or newborn coverage may not limit coverage  
18 for the length of a maternity or newborn stay in a hospital or  
19 for followup care outside of a hospital to any time period  
20 that is less than that determined to be medically necessary,  
21 in accordance with prevailing medical standards and consistent  
22 with ~~proposed 1996~~ guidelines for perinatal care of the  
23 American Academy of Pediatrics or the American College of  
24 Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by  
25 the treating obstetrical care provider or the pediatric care  
26 provider.

27 (c) ~~Nothing in~~ This section does not affect ~~affects~~  
28 any agreement between a health maintenance organization and a  
29 hospital or other health care provider with respect to  
30 reimbursement for health care services provided, rate  
31 negotiations with providers, or capitation of providers, and

1 this section does not prohibit ~~or prohibits~~ appropriate  
2 utilization review or case management by a health maintenance  
3 organization.

4 (d) Any health maintenance contract that provides  
5 coverage, benefits, or services for maternity or newborn care  
6 must provide coverage for postdelivery care for a mother and  
7 her newborn infant. The postdelivery care must include a  
8 postpartum assessment and newborn assessment and may be  
9 provided at the hospital, at the attending physician's office,  
10 at an outpatient maternity center, or in the home by a  
11 qualified licensed health care professional trained in mother  
12 and baby care. The services must include physical assessment  
13 of the newborn and mother, and the performance of any  
14 medically necessary clinical tests and immunizations in  
15 keeping with prevailing medical standards.

16 (e) A health maintenance organization subject to  
17 paragraph (b) shall communicate active case questions and  
18 concerns regarding postdelivery care directly to the treating  
19 physician or hospital in written form, in addition to other  
20 forms of communication. Such organization shall also use a  
21 process that ~~which~~ includes a written protocol for utilization  
22 review and quality assurance.

23 (f) Any health maintenance organization subject to  
24 paragraph (b) may not:

25 1. Deny to a mother or her newborn infant eligibility,  
26 or continued eligibility, to enroll or to renew coverage under  
27 the terms of the contract for the purpose of avoiding the  
28 requirements of this section.

29 2. Provide monetary payments or rebates to a mother to  
30 encourage the mother to accept less than the minimum  
31 protections available under this section.

1           3. Penalize or otherwise reduce or limit the  
2 reimbursement of an attending provider solely because the  
3 attending provider provided care to an individual participant  
4 or beneficiary in accordance with this section.

5           4. Provide incentives, monetary or otherwise, to an  
6 attending provider solely to induce the provider to provide  
7 care to an individual participant or beneficiary in a manner  
8 inconsistent with this section.

9           5. Subject to paragraph (i), restrict benefits for any  
10 portion of a period within a hospital length of stay required  
11 under paragraph (b) in a manner that is less favorable than  
12 the benefits provided for any preceding portion of such stay.

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

15                 1. Give birth in a hospital.

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

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

22           (i) This subsection does not prevent a health  
23 maintenance organization from imposing deductibles,  
24 coinsurance, or other cost-sharing in relation to benefits for  
25 hospital lengths of stay in connection with childbirth for a  
26 mother or her newborn infant under the contract or under  
27 health insurance coverage offered in connection with a group  
28 health plan, except that such coinsurance or other  
29 cost-sharing for any portion of a period within a hospital  
30 length of stay required under paragraph (b) may not be greater  
31

1 than such coinsurance or cost-sharing for any preceding  
2 portion of such stay.

3 Section 24. Section 641.3102, Florida Statutes, is  
4 amended to read:

5 641.3102 Restrictions upon expulsion or refusal to  
6 issue or renew contract.--

7 (1) A health maintenance organization that offers  
8 individual health maintenance contracts in this state may not  
9 decline to offer coverage to an eligible individual as  
10 required in s. 627.6487.

11 (2) A health maintenance organization shall not expel  
12 or refuse to renew the coverage of, or refuse to enroll, any  
13 individual member of a subscriber group on the basis of the  
14 race, color, creed, marital status, sex, or national origin of  
15 the subscriber or individual. A health maintenance  
16 organization shall not expel or refuse to renew the coverage  
17 of any individual member of a subscriber group on the basis of  
18 the age, health status, health care needs, or prospective  
19 costs of health care services of the subscriber or individual.  
20 Nothing in this section shall prohibit a health maintenance  
21 organization from requiring that, as a condition of continued  
22 eligibility for membership, dependents of a subscriber, upon  
23 reaching a specified age, convert to a converted contract or  
24 that individuals entitled to have payments for health costs  
25 made under Title XVIII of the United States Social Security  
26 Act, as amended, be issued a health maintenance contract for  
27 Medicare beneficiaries so long as the health maintenance  
28 organization is authorized to issue health maintenance  
29 contracts for Medicare beneficiaries.

30 Section 25. Section 641.31071, Florida Statutes, is  
31 created to read:

1           641.31071 Preexisting conditions.--  
2           (1) As used in this section, the term:  
3           (a) "Enrollment date" means, with respect to an  
4 individual covered under a group health maintenance  
5 organization contract, the date of enrollment of the  
6 individual in the plan or coverage or, if earlier, the first  
7 day of the waiting period of such enrollment.  
8           (b) "Late enrollee" means, with respect to coverage  
9 under a group health maintenance organization contract, a  
10 participant or beneficiary who enrolls under the contract  
11 other than during:  
12           1. The first period in which the individual is  
13 eligible to enroll under the plan.  
14           2. A special enrollment period, as provided under s.  
15 641.31072.  
16           (c) "Waiting period" means, with respect to a group  
17 health maintenance organization contract and an individual who  
18 is a potential participant or beneficiary under the contract,  
19 the period that must pass with respect to the individual  
20 before the individual is eligible to be covered for benefits  
21 under the terms of the contract.  
22           (2) Subject to the exceptions specified in subsection  
23 (4), a health maintenance organization that offers group  
24 coverage, may, with respect to a participant or beneficiary,  
25 impose a preexisting condition exclusion only if:  
26           (a) Such exclusion relates to a physical or mental  
27 condition, regardless of the cause of the condition, for which  
28 medical advice, diagnosis, care, or treatment was recommended  
29 or received within the 6-month period ending on the enrollment  
30 date;  
31

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

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

8           **(3) Genetic information shall not be treated as a**  
9 **condition described in paragraph (2)(a) in the absence of a**  
10 **diagnosis of the condition related to such information.**

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

14           **1. An individual who, as of the last day of the 30-day**  
15 **period beginning with the date of birth, is covered under**  
16 **creditable coverage.**

17           **2. A child who is adopted or placed for adoption**  
18 **before attaining 18 years of age and who, as of the last day**  
19 **of the 30-day period beginning on the date of the adoption or**  
20 **placement for adoption, is covered under creditable coverage.**  
21 **This provision shall not apply to coverage before the date of**  
22 **such adoption or placement for adoption.**

23           **3. Pregnancy.**

24           **(b) Subparagraphs (a)1. and 2. do not apply to an**  
25 **individual after the end of the first 63-day period during all**  
26 **of which the individual was not covered under any creditable**  
27 **coverage.**

28           **(5)(a) The term, "creditable coverage," means, with**  
29 **respect to an individual, coverage of the individual under any**  
30 **of the following:**

31

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

3           2. Health insurance coverage consisting of medical  
4 care, provided directly, through insurance or reimbursement or  
5 otherwise, and including terms and services paid for as  
6 medical care, under any hospital or medical service policy or  
7 certificate, hospital or medical service plan contract, or  
8 health maintenance contract offered by a health insurance  
9 issuer.

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

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

15           5. Chapter 55 of Title 10, United States Code.

16           6. A medical care program of the Indian Health Service  
17 or of a tribal organization.

18           7. The Florida Comprehensive Health Association or  
19 another state health benefit risk pool.

20           8. A health plan offered under chapter 89 of Title 5,  
21 United States Code.

22           9. A public health plan as defined by rule of the  
23 department. To the greatest extent possible, such rules must  
24 be consistent with regulations adopted by the United States  
25 Department of Health and Human Services.

26           10. A health benefit plan under s. 5(e) of the Peace  
27 Corps Act (22 United States Code, 2504(e)).

28           (b) Creditable coverage does not include coverage that  
29 consists solely of one or more or any combination thereof of  
30 the following excepted benefits:

31

1           1. Coverage only for accident, or disability income  
2 insurance, or any combination thereof.

3           2. Coverage issued as a supplement to liability  
4 insurance.

5           3. Liability insurance, including general liability  
6 insurance and automobile liability insurance.

7           4. Workers' compensation or similar insurance.

8           5. Automobile medical payment insurance.

9           6. Credit-only insurance.

10          7. Coverage for onsite medical clinics.

11          8. Other similar insurance coverage, specified in  
12 rules adopted by the department, under which benefits for  
13 medical care are secondary or incidental to other insurance  
14 benefits. To the greatest extent possible, such rules must be  
15 consistent with regulations adopted by the United States  
16 Department of Health and Human Services.

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

19           1. Limited scope dental or vision benefits.

20           2. Benefits or long-term care, nursing home care, home  
21 health care, community-based care, or any combination of  
22 these.

23           3. Such other similar, limited benefits as are  
24 specified in rules adopted by the department. To the greatest  
25 extent possible, such rules must be consistent with  
26 regulations adopted by the United States Department of Health  
27 and Human Services.

28          (d) The following benefits do not constitute  
29 creditable coverage if offered as independent, noncoordinated  
30 benefits:

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



1           2. Hospital indemnity or other fixed indemnity  
2 insurance.

3           (e) Benefits provided through Medicare supplemental  
4 health insurance, as defined under s. 1882(g)(1) of the Social  
5 Security Act, coverage supplemental to the coverage provided  
6 under chapter 55 of Title 10, United States Code, and similar  
7 supplemental coverage provided to coverage under a group  
8 health plan are not considered creditable coverage if offered  
9 as a separate insurance policy.

10           (6)(a) A period of creditable coverage may not be  
11 counted, with respect to enrollment of an individual under a  
12 group health maintenance organization contract, if, after such  
13 period and before the enrollment date, there was a 63-day  
14 period during all of which the individual was not covered  
15 under any creditable coverage.

16           (b) Any period during which an individual is in a  
17 waiting period, or in an affiliation period as defined in  
18 subsection (9), for any coverage under a group health  
19 maintenance organization contract may not be taken into  
20 account in determining the 63-day period under paragraph (a)  
21 or paragraph (4)(b).

22           (7)(a) Except as otherwise provided under paragraph  
23 (b), a health maintenance organization shall count a period of  
24 creditable coverage without regard to the specific benefits  
25 covered under the period.

26           (b) A health maintenance organization may elect to  
27 count as creditable coverage, coverage of benefits within each  
28 of several classes or categories of benefits specified in  
29 rules adopted by the department rather than as provided under  
30 paragraph (a). Such election shall be made on a uniform basis  
31 for all participants and beneficiaries. Under such election, a

1 health maintenance organization shall count a period of  
2 creditable coverage with respect to any class or category of  
3 benefits if any level of benefits is covered within such class  
4 or category.

5 (c) In the case of an election with respect to a  
6 health maintenance organization under paragraph (b), the  
7 organization shall:

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

12 2. Include in such statements a description of the  
13 effect of this election.

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

18 (b) A health maintenance organization that offers  
19 group coverage shall provide the certification described in  
20 paragraph (a):

21 1. At the time an individual ceases to be covered  
22 under the plan or otherwise becomes covered under a COBRA  
23 continuation provision or continuation pursuant to s.  
24 627.6692.

25 2. In the case of an individual becoming covered under  
26 a COBRA continuation provision or pursuant to s. 627.6692, at  
27 the time the individual ceases to be covered under such a  
28 provision.

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

1  
2 The certification under subparagraph 1. may be provided, to  
3 the extent practicable, at a time consistent with notices  
4 required under any applicable COBRA continuation provision or  
5 continuation pursuant to s. 627.6692.

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

7 1. The period of creditable coverage of the individual  
8 under the contract and the coverage, if any, under such COBRA  
9 continuation provision or continuation pursuant to s.  
10 627.6692; and

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

13 (d) In the case of an election described in subsection  
14 (7) by a health maintenance organization, if the organization  
15 enrolls an individual for coverage under the plan and the  
16 individual provides a certification of coverage of the  
17 individual, as provided by this subsection:

18 1. Upon request of such health maintenance  
19 organization, the insurer or health maintenance organization  
20 that issued the certification provided by the individual shall  
21 promptly disclose to such requesting organization information  
22 on coverage of classes and categories of health benefits  
23 available under such insurer's or health maintenance  
24 organization's plan or coverage.

25 2. Such insurer or health maintenance organization may  
26 charge the requesting organization for the reasonable cost of  
27 disclosing such information.

28 (e) The department shall adopt rules to prevent an  
29 insurer's or health maintenance organization's failure to  
30 provide information under this subsection with respect to  
31 previous coverage of an individual from adversely affecting

1 any subsequent coverage of the individual under another group  
2 health plan or health maintenance organization coverage.

3 (9)(a) A health maintenance organization may provide  
4 for an affiliation period with respect to coverage through the  
5 organization only if:

6 1. No preexisting condition exclusion is imposed with  
7 respect to coverage through the organization;

8 2. The period is applied uniformly without regard to  
9 any health-status-related factors; and

10 3. Such period does not exceed 2 months or 3 months in  
11 the case of a late enrollee.

12 (b) For the purposes of this section, the term  
13 "affiliation period" means a period that, under the terms of  
14 the coverage offered by the health maintenance organization,  
15 must expire before the coverage becomes effective. The  
16 organization is not required to provide health care services  
17 or benefits during such period and no premium may be charged  
18 to the participant or beneficiary for any coverage during the  
19 period. Such period begins on the enrollment date and runs  
20 concurrently with any waiting period under the plan.

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

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

27 (b) The department shall adopt rules that provide a  
28 process whereby individuals who need to establish creditable  
29 coverage for periods before July 1, 1996, and who would have  
30 such coverage credited but for paragraph (a), may be given  
31

1 credit for creditable coverage for such periods through the  
2 presentation of documents or other means.

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

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

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

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

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

20 (b) A health maintenance organization is not subject  
21 to any penalty or enforcement action with respect to the  
22 organization's crediting, or not crediting, such coverage if  
23 the organization has sought to comply in good faith with  
24 applicable provisions of this section.

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

30 Section 26. Section 641.31072, Florida Statutes, is  
31 created to read:

1           641.31072 Special enrollment periods.--

2           (1) A health maintenance organization that issues a  
3 group health insurance policy shall permit an employee who is  
4 eligible, but not enrolled, for coverage under the terms of  
5 the contract, or a dependent of such an employee if the  
6 dependent is eligible but not enrolled for coverage under such  
7 terms, to enroll for coverage under the terms of the contract  
8 if each of the following conditions is met:

9           (a) The employee or dependent was covered under a  
10 group health plan or had health insurance coverage at the time  
11 coverage was previously offered to the employee or dependent.  
12 For the purpose of this section, the terms "group health plan"  
13 and "health insurance coverage" have the same meaning ascribed  
14 in s. 2791 of the Public Health Service Act.

15           (b) The employee stated in writing at such time that  
16 coverage under a group health plan or health insurance  
17 coverage was the reason for declining enrollment, but only if  
18 the plan sponsor or health maintenance organization, if  
19 applicable, required such a statement at such time and  
20 provided the employee with notice of such requirement and the  
21 consequences of such requirement at such time.

22           (c) The employee's or dependent's coverage described  
23 in paragraph (a):

24           1. Was under a COBRA continuation provision or  
25 continuation pursuant to s. 627.6692, and the coverage under  
26 such provision was exhausted; or

27           2. Was not under such a provision and the coverage was  
28 terminated as a result of loss of eligibility for the  
29 coverage, including legal separation, divorce, death,  
30 termination of employment, or reduction in the number of hours  
31 of employment, or the coverage was terminated as a result of

1 the termination of employer contributions toward such  
2 coverage.

3 (d) Under the terms of the contract, the employee  
4 requests such enrollment not later than 30 days after the date  
5 of exhaustion of coverage described in subparagraph (c)1., or  
6 termination or employer contribution described in subparagraph  
7 (c)2.

8 (2) For dependent beneficiaries, if:

9 (a) A group health maintenance organization contract  
10 makes coverage available with respect to a dependent of an  
11 individual;

12 (b) The individual is a participant under the  
13 contract, or has met any waiting period applicable to becoming  
14 a participant under the contract, and is eligible to be  
15 enrolled under the contract but for a failure to enroll during  
16 a previous enrollment period; and

17 (c) A person becomes such a dependent of the  
18 individual through marriage, birth, or adoption or placement  
19 for adoption,

20  
21 the health maintenance organization shall provide for a  
22 dependent special enrollment period described in subsection  
23 (3) during which the person, or, if not otherwise enrolled,  
24 the individual, may be enrolled under the plan as a dependent  
25 of the individual, and in the case of the birth or adoption of  
26 a child, the spouse of the individual may be enrolled as a  
27 dependent of the individual if such spouse is otherwise  
28 eligible for coverage.

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

1           (a) The date dependent coverage is made available; or  
2           (b) The date of the marriage, birth, or adoption or  
3 placement for adoption described in subsection (2)(c).

4           (4) If an individual seeks to enroll a dependent  
5 during the first 30 days of such a dependent special  
6 enrollment period, the coverage of the dependent shall become  
7 effective:

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

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

13           (c) In the case of a dependent's adoption or placement  
14 for adoption, the date of such adoption or placement for  
15 adoption.

16           Section 27. Section 641.31073, Florida Statutes, is  
17 created to read:

18           641.31073 Prohibiting discrimination against  
19 individual participants and beneficiaries based on health  
20 status.--

21           (1) Subject to subsection (2), a health maintenance  
22 organization that offers group health insurance coverage may  
23 not establish rules for eligibility, including continued  
24 eligibility, of an individual to enroll under the terms of the  
25 contract based on any of the following health-status-related  
26 factors in relation to the individual or a dependent of the  
27 individual:

28           (a) Health status.

29           (b) Medical condition, including physical and mental  
30 illnesses.

31           (c) Claims experience.



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

1           2. Prevent a health maintenance organization offering  
2 group health insurance coverage from establishing premium  
3 discounts or rebates or modifying otherwise applicable  
4 copayments or deductibles in return for adherence to programs  
5 of health promotion and disease prevention.

6           Section 28. Section 641.31074, Florida Statutes, is  
7 created to read:

8           641.31074 Guaranteed renewability of coverage.--

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

13           (2) A health maintenance organization may nonrenew or  
14 discontinue a contract based only on one or more of the  
15 following conditions:

16           (a) The contract holder has failed to pay premiums or  
17 contributions in accordance with the terms of the contract or  
18 the health maintenance organization has not received timely  
19 premium payments.

20           (b) The contract holder has performed an act or  
21 practice that constitutes fraud or made an intentional  
22 misrepresentation of material fact under the terms of the  
23 contract.

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

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

30           (e) There is no longer any enrollee in connection with  
31 such plan who lives, resides, or works in the service area of

1 the health maintenance organization or in the area in which  
2 the health maintenance organization is authorized to do  
3 business and, in the case of the small-group market, the  
4 organization would deny enrollment with respect to such plan  
5 under s. 627.6699(5)(i).

6 (f) In the case of coverage that is made available  
7 only through one or more bona fide associations as defined in  
8 s. 627.6571(5), the membership of an employer in the  
9 association, on the basis of which the coverage is provided,  
10 ceases, but only if such coverage is terminated under this  
11 paragraph uniformly without regard to any  
12 health-status-related factor that relates to any covered  
13 individuals.

14 (3)(a) A health maintenance organization may  
15 discontinue offering a particular contract form for group  
16 coverage offered in the small-group market or large-group  
17 market only if:

18 1. The health maintenance organization provides notice  
19 to each contract holder provided coverage of this form in such  
20 market, and participants and beneficiaries covered under such  
21 coverage, of such discontinuation at least 90 days prior to  
22 the date of the discontinuation of such coverage;

23 2. The health maintenance organization offers to each  
24 contract holder provided coverage of this form in such market  
25 the option to purchase all other health insurance coverage  
26 currently being offered by the health maintenance organization  
27 in such market; and

28 3. In exercising the option to discontinue coverage of  
29 this form and in offering the option of coverage under  
30 subparagraph 2., the health maintenance organization acts  
31 uniformly without regard to the claims experience of those

1 contract holders or any health-status-related factor that  
2 relates to any participants or beneficiaries covered or new  
3 participants or beneficiaries who may become eligible for such  
4 coverage.

5 (b)1. In any case in which a health maintenance  
6 organization elects to discontinue offering all coverage in  
7 the small-group market or the large-group market, or both, in  
8 this state, coverage may be discontinued by the insurer only  
9 if:

10 a. The health maintenance organization provides notice  
11 to the department and to each contract holder, and  
12 participants and beneficiaries covered under such coverage, of  
13 such discontinuation at least 180 days prior to the date of  
14 the discontinuation of such coverage; and

15 b. All health insurance issued or delivered for  
16 issuance in this state in such markets are discontinued and  
17 coverage under such health insurance coverage in such market  
18 is not renewed.

19 2. In the case of a discontinuation under subparagraph  
20 1. in a market, the health maintenance organization may not  
21 provide for the issuance of any health maintenance  
22 organization contract coverage in the market in this state  
23 during the 5-year period beginning on the date of the  
24 discontinuation of the last insurance contract not renewed.

25 (4) At the time of coverage renewal, a health  
26 maintenance organization may modify the coverage for a product  
27 offered:

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

29 (b) In the small-group market if, for coverage that is  
30 available in such market other than only through one or more  
31 bona fide associations, as defined in s. 627.6571(5), such

1 modification is consistent with s. 627.6699 and effective on a  
2 uniform basis among group health plans with that product.

3 (5) In applying this section in the case of health  
4 insurance coverage that is made available by a health  
5 maintenance organization in the small-group market or  
6 large-group market to employers only through one or more  
7 associations, a reference to "contract holder" is deemed, with  
8 respect to coverage provided to an employer member of the  
9 association, to include a reference to such employer.

10 Section 29. Section 641.3921, Florida Statutes, is  
11 amended to read:

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

30  
31

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

4           (2) Replacement of any discontinued group coverage by  
5 similar group coverage within 31 days;

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

8           (4) Disenrollment for cause. When the requirements of  
9 paragraphs (a), (b), and (c) have been met, a health  
10 maintenance organization may disenroll a subscriber for cause  
11 if the subscriber's behavior is disruptive, unruly, abusive,  
12 or uncooperative to the extent that his continuing membership  
13 in the organization seriously impairs the organization's  
14 ability to furnish services to either the subscriber or other  
15 subscribers.

16           (a) Effort to resolve the problem. The organization  
17 must make a serious effort to resolve the problem presented by  
18 the subscriber, including the use or attempted use of  
19 subscriber grievance procedures.

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

23           (c) Documentation. The organization must document the  
24 problems, efforts, and medical conditions as described in this  
25 subsection;

26           (5) Willful and knowing misuse of the health  
27 maintenance organization identification membership card by the  
28 subscriber;

29           (6) Willful and knowing furnishing to the organization  
30 by the subscriber of incorrect or incomplete information for  
31

1 the purpose of fraudulently obtaining coverage or benefits  
2 from the organization; or

3 (7) The subscriber has left the geographic area of the  
4 health maintenance organization with the intent to relocate or  
5 establish a new residence outside the organization's  
6 geographic area.

7 Section 30. Section 641.3922, Florida Statutes, is  
8 amended to read:

9 641.3922 Conversion contracts; conditions.--Issuance  
10 of a converted contract shall be subject to the following  
11 conditions:

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

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

18 (3) CONVERSION PREMIUM.--The premium for the converted  
19 contract shall be determined in accordance with premium rates  
20 applicable to the age and class of risk of each person to be  
21 covered under the converted contract and to the type and  
22 amount of coverage provided. However, the premium for the  
23 converted contract may not exceed 200 percent of the standard  
24 risk rate, as established by the Florida Comprehensive Health  
25 Association and adjusted for differences in benefit levels and  
26 structure between the converted policy and the policy offered  
27 by the Florida Comprehensive Health Association. The mode of  
28 payment for the converted contract shall be quarterly or more  
29 frequently at the option of the organization, unless otherwise  
30 mutually agreed upon between the subscriber and the  
31 organization.

1           (4) EFFECTIVE DATE OF COVERAGE.--The effective date of  
2 the converted contract shall be the day following the  
3 termination of coverage under the group health maintenance  
4 contract. However, until application is made and the first  
5 premium is paid, the health maintenance organization may  
6 charge the subscriber, on a fee-for-service basis, for any  
7 services rendered to the subscriber after the date in which  
8 the subscriber ceases to be eligible under the group health  
9 maintenance contract. When application is made and the first  
10 premium is paid, the organization shall reimburse the  
11 subscriber for any payment made by the subscriber for covered  
12 services under the converted contract.

13           (5) SCOPE OF COVERAGE.--The converted contract shall  
14 cover the subscriber or dependents who were covered by the  
15 group health maintenance contract on the date of termination  
16 of coverage. At the option of the health maintenance  
17 organization, a separate converted contract may be issued to  
18 cover any dependent.

19           (6) OPTIONAL COVERAGE.--The health maintenance  
20 organization shall not be required to issue a converted  
21 contract covering any person if such person is or could be  
22 covered by Medicare, Title XVIII of the Social Security Act,  
23 as added by the Social Security Amendments of 1965, or as  
24 later amended or superseded. Furthermore, the health  
25 maintenance organization shall not be required to issue a  
26 converted health maintenance contract covering any person if:

27           (a)1. The person is covered for similar benefits by  
28 another hospital, surgical, medical, or major medical expense  
29 insurance policy or hospital or medical service subscriber  
30 contract or medical practice or other prepayment plan or by  
31 any other plan or program;



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

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

8           (b) A converted health maintenance contract may  
9 include a provision whereby the health maintenance  
10 organization may request information, in advance of any  
11 premium due date of a health maintenance contract, of any  
12 person covered thereunder as to whether:

13           1. He is covered for similar benefits by another  
14 hospital, surgical, medical, or major medical expense  
15 insurance policy or hospital or medical service subscriber  
16 contract or medical practice or other prepayment plan or by  
17 any other plan or program;

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

21           3. Similar benefits are provided for or are available  
22 to the person pursuant to or in accordance with the  
23 requirements of any state or federal law.

24           (7) REASONS FOR CANCELLATION; TERMINATION.--The  
25 converted health maintenance contract must contain a  
26 cancellation or nonrenewability clause providing that the  
27 health maintenance organization may refuse to renew the  
28 contract of any person covered thereunder, but cancellation or  
29 nonrenewal must be limited to one or more of the following  
30 reasons:

31

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

4 (b) Eligibility of the covered person for coverage  
5 under Medicare, Title XVIII of the Social Security Act, as  
6 added by the Social Security Amendments of 1965, or as later  
7 amended or superseded, or under any other state or federal law  
8 providing for benefits similar to those provided by the  
9 converted health maintenance contract, except for Medicaid,  
10 Title XIX of the Social Security Act, as amended by the Social  
11 Security Amendments of 1965, or as later amended or  
12 superseded.

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

15 (d) Willful and knowing misuse of the health  
16 maintenance organization identification membership card by the  
17 subscriber or the willful and knowing furnishing to the  
18 organization by the subscriber of incorrect or incomplete  
19 information for the purpose of fraudulently obtaining coverage  
20 or benefits from the organization.

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

22 (f) 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 (g) A dependent of the subscriber has reached the  
27 limiting age under the converted contract, subject to  
28 subsection (12); but the refusal to renew coverage shall apply  
29 only to coverage of the dependent, except in the case of  
30 handicapped children.

31

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

4 (8) BENEFITS OFFERED.--A health maintenance  
5 organization shall not be required to issue a converted  
6 contract which provides benefits in excess of those provided  
7 under the group health maintenance contract from which  
8 conversion is made. The converted health maintenance contract  
9 shall meet the requirements of law pertaining to health  
10 maintenance contracts and shall include a level of benefits  
11 for minimum services which is substantially similar to the  
12 level of benefits for these services included in the group  
13 health maintenance organization contract from which the  
14 termination is made.

15 (9) PREEXISTING CONDITION PROVISION.--The converted  
16 health maintenance contract shall not exclude a preexisting  
17 condition not excluded by the group contract. However, the  
18 converted health maintenance contract may provide that any  
19 coverage benefits thereunder may be reduced by the amount of  
20 any coverage or benefits under the group health maintenance  
21 contract after the termination of the person's coverage or  
22 benefits thereunder. The converted health maintenance  
23 contract may also include provisions so that during the first  
24 coverage year the coverage or benefits under the converted  
25 contract, together with the coverage or benefits under the  
26 group health maintenance contract, shall not exceed those that  
27 would have been provided had the individual's coverage or  
28 benefits under the group contract remained in force and  
29 effect.

30 (10) ALTERNATE PLANS.--The health maintenance  
31 organization shall offer a standard health benefit plan as

1 established pursuant to s. 627.6699(12).The health  
 2 maintenance organization may, at its option, also offer  
 3 alternative plans for group health conversion in addition to  
 4 those required by this section, provided any alternative plan  
 5 is approved by the department or is a converted policy,  
 6 approved under s. 627.6675 and issued by an insurance company  
 7 authorized to transact insurance in this state. Approval by  
 8 the department of an alternative plan shall be based on  
 9 compliance by the alternative plan with the provisions of this  
 10 part and the rules promulgated thereunder, applicable  
 11 provisions of the Florida Insurance Code and rules promulgated  
 12 thereunder, and any other applicable law.

13 (11) RETIREMENT COVERAGE.--In the event that coverage  
 14 would be continued under the group health maintenance contract  
 15 on an employee following his retirement prior to the time he  
 16 is or could be covered by Medicare, he may elect, in lieu of  
 17 such continuation of group coverage, to have the same  
 18 conversion rights as would apply had his coverage terminated  
 19 at retirement by reason of termination of employment or  
 20 membership.

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

24 (a) To the surviving spouse, if any, at the death of  
 25 the subscriber, with respect to the spouse and such children  
 26 whose coverages under the group health maintenance contract  
 27 terminate by reason of such death, otherwise to each surviving  
 28 child whose coverage under the group health maintenance  
 29 contract terminates by reason of such death or, if the group  
 30 contract provides for continuation of dependents' coverages  
 31

1 following the subscriber's death, at the end of such  
2 continuation;

3 (b) To the former spouse whose coverage would  
4 otherwise terminate because of annulment or dissolution of  
5 marriage, if the former spouse is dependent for financial  
6 support;

7 (c) To the spouse of the subscriber upon termination  
8 of coverage of the spouse, while the subscriber remains  
9 covered under the group health maintenance contract, by reason  
10 of ceasing to be a qualified family member under the group  
11 health maintenance contract, with respect to the spouse and  
12 such children whose coverages under the group health  
13 maintenance contract terminate at the same time; or

14 (d) To a child solely with respect to himself upon  
15 termination of his coverage by reason of ceasing to be a  
16 qualified family member under the group health maintenance  
17 contract or under any converted contract, if a conversion  
18 privilege is not otherwise provided above with respect to such  
19 termination.

20 (13) GROUP COVERAGE IN LIEU OF INDIVIDUAL  
21 COVERAGE.--The health maintenance organization may elect to  
22 provide group health maintenance organization coverage through  
23 a group converted contract in lieu of the issuance of an  
24 individual converted contract.

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

28 Section 31. (1) The changes made by this act to  
29 section 641.3922, Florida Statutes, apply to conversion  
30 policies offered, sold, issued, or renewed on or after January  
31 1, 1998.

1           (2) An individual who was entitled on July 1, 1997, to  
2 a conversion contract under section 641.3922, Florida  
3 Statutes, shall be entitled on January 1, 1998, to a  
4 conversion contract meeting the requirements of section  
5 641.3922, Florida Statutes, as amended by this act. Such an  
6 individual shall remain entitled to a conversion contract for  
7 the same period of time after January 1, 1998, that the  
8 individual would have remained eligible after July 1, 1997,  
9 including the condition that application for coverage be made  
10 within 63 days of the termination of the group coverage.

11           Section 32. The provisions of this act fulfill an  
12 important state interest.

13           Section 33. Section 627.6576, Florida Statutes, is  
14 repealed.

15           Section 34. (1) Except as provided in subsection (2)  
16 and as otherwise provided in this act, the changes made by  
17 this act apply to policies or contracts with plan years that  
18 begin on or after July 1, 1997.

19           (2) Except as provided in section 627.6561(9), (10),  
20 and (11), and section 641.31071(10), (11), and (12), Florida  
21 Statutes, in the case of a group health plan or group health  
22 insurance contract maintained pursuant to one or more  
23 collective bargaining agreements between employee  
24 representatives and one or more employers which is ratified  
25 before this act becomes a law, sections 627.6561, 627.65615,  
26 627.65625, 627.6571, 627.6699, 641.31071, 641.31072,  
27 641.31073, and 641.31074, Florida Statutes, except for section  
28 627.6561(8)(b), Florida Statutes, as amended or created by  
29 this act, apply to policies or contracts with plan years that  
30 begin on or after the later of:

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

5           (b) July 1, 1997.

6           Section 35. The Banking and Insurance Committee of the  
7 Senate and the Health Care Services Committee of the House of  
8 Representatives are directed to conduct an interim study to  
9 make recommendations to the Legislature for the 1998 Regular  
10 Session regarding high cost insureds and potential insureds  
11 and how the needs of such insureds are being met under this  
12 act. The Department of Insurance is directed to assist with  
13 the provision of information and the gathering of data as  
14 required or deemed appropriate by the committees.

15           Section 36. The amendments in this act to s.  
16 627.6487(3)(b)2., Florida Statutes, and to ss. 627.6675 and  
17 641.3922, Florida Statutes, shall not take effect unless the  
18 Health Care Finance Administration of the United States  
19 Department of Health and Human Services approves this act as  
20 providing an acceptable alternative mechanism, as provided in  
21 s. 2744 of the Public Health Service Act, or the act is deemed  
22 approved due to the expiration of the time periods prescribed  
23 in s. 2744(b)(5) of the Public Health Service Act.

24           Section 37. Except as otherwise provided in this act,  
25 this act shall take effect upon becoming a law.  
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