1 CHAMBER ACTION
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6 The Committee on Insurance recommends the following:
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8 **Committee Substitute**
9 Remove the entire bill and insert:
10 A bill to be entitled
11 An act relating to health insurance; amending s. 395.301,
12 F.S.; requiring certain licensed facilities to make
13 certain information public electronically; requiring
14 notice; providing requirements; requiring health care
15 facilities to provide patients with reasonable estimates
16 of prospective charges; amending s. 408.909, F.S.;
17 revising a definition; authorizing plans to limit the term
18 of coverage; extending the required period without
19 coverage before participation eligibility; extending a
20 program expiration date; amending s. 627.410, F.S.;
21 exempting individuals and certain groups from laws
22 restricting or limiting coinsurance, copayments, or annual
23 or lifetime maximum payments; amending s. 627.6487, F.S.;
24 revising a definition of "eligible individual" for
25 purposes of availability of individual health insurance
26 coverage; authorizing insurers to impose certain
27 surcharges or premium charges for creditable coverage
28 earned in certain states; amending s. 627.6561, F.S.;

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29 requiring additional information in a certification
30 relating to certain creditable coverage for purposes of
31 eligibility for exclusion from preexisting condition
32 requirements; amending s. 627.667, F.S.; deleting a
33 limitation on certain application of extension of benefits
34 provisions; amending s. 627.6692, F.S.; extending a time
35 period for continuation of certain coverage under group
36 health plans; amending s. 627.6699, F.S.; revising certain
37 definitions; revising enrollment period criteria for
38 certain health benefit plans; requiring small employers to
39 provide certain health benefit plan information to
40 employees; providing a limitation; revising certain rate
41 adjustment criteria; authorizing separation of experience
42 of certain small employer groups for certain purposes;
43 amending s. 641.31, F.S.; specifying nonapplication of
44 certain health maintenance contract filing requirements to
45 certain group health insurance policies, with exceptions;
46 creating s. 641.31075, F.S.; providing compliance
47 requirements for health maintenance organizations
48 replacing certain coverages; amending s. 641.3111, F.S.;
49 providing additional requirements for extension of
50 benefits under group health maintenance contracts;
51 providing severability; providing an effective date.
52
53 Be It Enacted by the Legislature of the State of Florida:
54
55 Section 1. Subsection (7) is added to section 395.301,
56 Florida Statutes, to read:

57 395.301 Itemized patient bill; form and content prescribed
58 by the agency.--
59 (7)(a) Each licensed facility not operated by the state
60 shall make available to the public on its Internet website or by
61 other electronic means its master list of charges and codes and
62 a description of services of the top 100 diagnosis-related
63 groups discharged from the hospital for that year using the CMS
64 grouper applicable to that year and the top 100 outpatient
65 occasions of diagnostic and therapeutic procedures performed
66 using the Healthcare Common Procedure Coding System. For
67 purposes of this paragraph, "CMS grouper" means a system of
68 classification used by the Centers for Medicare and Medicaid
69 Services to assign an inpatient discharge into a diagnosis-
70 related group based on diagnosis codes, procedure codes, and
71 demographic information. The facility shall place a notice in
72 the reception areas that such information is available
73 electronically. The facility's list of charges and codes and the
74 description of services shall be consistent with federal
75 electronic transmission uniform standards under the Health
76 Insurance Portability and Accountability Act (HIPAA). Changes to
77 the data shall be posted at least 30 days prior to
78 implementation of changes.
79 (b) A health care facility shall, upon request, furnish a
80 prospective patient, prior to provision of medical services, a
81 reasonable estimate of charges for such services. Such estimate
82 shall not preclude the health care facility from exceeding the
83 estimate or making additional charges based on changes in the
84 patient's condition or treatment needs.

85 Section 2. Paragraph (e) of subsection (2), subsection
86 (3), paragraph (c) of subsection (5), and subsection (10) of
87 section 408.909, Florida Statutes, are amended to read:
88 408.909 Health flex plans.--
89 (2) DEFINITIONS.--As used in this section, the term:
90 (e) "Health flex plan" means a health plan approved under
91 subsection (3) which guarantees payment for specified health
92 care coverage provided to the enrollee who purchases coverage
93 directly from the plan or through a small business purchasing
94 arrangement sponsored by a local government.
95 (3) PILOT PROGRAM.--The agency and the department shall
96 each approve or disapprove health flex plans that provide health
97 care coverage for eligible participants who reside in the three
98 areas of the state that have the highest number of uninsured
99 persons, as identified in the Florida Health Insurance Study
100 conducted by the agency and in Indian River County. A health
101 flex plan may limit or exclude benefits otherwise required by
102 law for insurers offering coverage in this state, may cap the
103 total amount of claims paid per year per enrollee, may limit the
104 number of enrollees or the term of coverage, or may take any
105 combination of those actions.
106 (a) The agency shall develop guidelines for the review of
107 applications for health flex plans and shall disapprove or
108 withdraw approval of plans that do not meet or no longer meet
109 minimum standards for quality of care and access to care.
110 (b) The department shall develop guidelines for the review
111 of health flex plan applications and shall disapprove or shall
112 withdraw approval of plans that:

113 1. Contain any ambiguous, inconsistent, or misleading
114 provisions or any exceptions or conditions that deceptively
115 affect or limit the benefits purported to be assumed in the
116 general coverage provided by the health flex plan;
117 2. Provide benefits that are unreasonable in relation to
118 the premium charged or contain provisions that are unfair or
119 inequitable or contrary to the public policy of this state, that
120 encourage misrepresentation, or that result in unfair
121 discrimination in sales practices; or
122 3. Cannot demonstrate that the health flex plan is
123 financially sound and that the applicant is able to underwrite
124 or finance the health care coverage provided.
125 (c) The agency and the department may adopt rules as
126 needed to administer this section.
127 (5) ELIGIBILITY.--Eligibility to enroll in an approved
128 health flex plan is limited to residents of this state who:
129 (c) Are not covered by a private insurance policy and are
130 not eligible for coverage through a public health insurance
131 program, such as Medicare or Medicaid, or another public health
132 care program, such as KidCare, and have not been covered at any
133 time during the past 12 ~~6~~ months; and
134 (10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.
135 Section 3. Paragraph (b) of subsection (6) of section
136 627.410, Florida Statutes, is amended to read:
137 627.410 Filing, approval of forms.--
138 (6)
139 (b) The department may establish by rule, for each type of
140 health insurance form, procedures to be used in ascertaining the

141 reasonableness of benefits in relation to premium rates and may,
142 by rule, exempt from any requirement of paragraph (a) any health
143 insurance policy form or type thereof (as specified in such
144 rule) to which form or type such requirements may not be
145 practically applied or to which form or type the application of
146 such requirements is not desirable or necessary for the
147 protection of the public. A law restricting or limiting
148 deductibles, coinsurance, copayments, or annual or lifetime
149 maximum payments shall not apply to any health plan policy
150 offered or delivered to an individual or to a group of 51 or
151 more persons that provides coverage as described in s.
152 641.31071(5)(a)2. With respect to any health insurance policy
153 form or type thereof which is exempted by rule from any
154 requirement of paragraph (a), premium rates filed pursuant to
155 ss. 627.640 and 627.662 shall be for informational purposes.
156 Section 4. Paragraph (b) of subsection (3) of section
157 627.6487, Florida Statutes, is amended, and paragraph (c) is
158 added to subsection (4) of said section, to read:
159 627.6487 Guaranteed availability of individual health
160 insurance coverage to eligible individuals.--
161 (3) For the purposes of this section, the term "eligible
162 individual" means an individual:
163 (b) Who is not eligible for coverage under:
164 1. A group health plan, as defined in s. 2791 of the
165 Public Health Service Act;
166 2. A conversion policy or contract issued by an authorized
167 insurer or health maintenance organization under s. 627.6675 or
168 s. 641.3921, respectively, offered to an individual who is no

169 longer eligible for coverage under either an insured or self-
170 insured group health ~~employer~~ plan or group health insurance
171 policy;
172 3. Part A or part B of Title XVIII of the Social Security
173 Act; or
174 4. A state plan under Title XIX of such act, or any
175 successor program, and does not have other health insurance
176 coverage;
177 (4)
178 (c) If the individual's most recent period of creditable
179 coverage was earned in a state other than this state, an insurer
180 issuing a policy that complies with paragraph (a) may impose a
181 surcharge or charge a premium for such policy equal to that
182 permitted in the state in which such creditable coverage was
183 earned.
184 Section 5. Paragraph (c) of subsection (8) of section
185 627.6561, Florida Statutes, is amended to read:
186 627.6561 Preexisting conditions.--
187 (8)
188 (c) The certification described in this section is a
189 written certification that must include:
190 1. The period of creditable coverage of the individual
191 under the policy and the coverage, if any, under such COBRA
192 continuation provision or continuation pursuant to s. 627.6692.~~;~~
193 ~~and~~
194 2. The waiting period, if any, imposed with respect to the
195 individual for any coverage under such policy.

196 3. A statement that the creditable coverage was provided
197 under a group health plan, a group or individual health
198 insurance policy, or a health maintenance organization contract,
199 the state in which such coverage was provided, and whether or
200 not such individual was eligible for a conversion policy under
201 such coverage.
202 Section 6. Subsection (6) of section 627.667, Florida
203 Statutes, is amended to read:
204 627.667 Extension of benefits.--
205 (6) This section also applies to holders of group
206 certificates which are renewed, delivered, or issued for
207 delivery to residents of this state under group policies
208 effectuated or delivered outside this state~~, unless a succeeding~~
209 ~~carrier under a group policy has agreed to assume liability for~~
210 ~~the benefits~~.
211 Section 7. Paragraph (e) of subsection (5) of section
212 627.6692, Florida Statutes, is amended to read:
213 627.6692 Florida Health Insurance Coverage Continuation
214 Act.--
215 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--
216 (e)1. A covered employee or other qualified beneficiary
217 who wishes continuation of coverage must pay the initial premium
218 and elect such continuation in writing to the insurance carrier
219 issuing the employer's group health plan within 63 ~~30~~ days after
220 receiving notice from the insurance carrier under paragraph (d).
221 Subsequent premiums are due by the grace period expiration date.
222 The insurance carrier or the insurance carrier's designee shall
223 process all elections promptly and provide coverage

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224 retroactively to the date coverage would otherwise have
225 terminated. The premium due shall be for the period beginning on
226 the date coverage would have otherwise terminated due to the
227 qualifying event. The first premium payment must include the
228 coverage paid to the end of the month in which the first payment
229 is made. After the election, the insurance carrier must bill the
230 qualified beneficiary for premiums once each month, with a due
231 date on the first of the month of coverage and allowing a 30-day
232 grace period for payment.
233 2. Except as otherwise specified in an election, any
234 election by a qualified beneficiary shall be deemed to include
235 an election of continuation of coverage on behalf of any other
236 qualified beneficiary residing in the same household who would
237 lose coverage under the group health plan by reason of a
238 qualifying event. This subparagraph does not preclude a
239 qualified beneficiary from electing continuation of coverage on
240 behalf of any other qualified beneficiary.
241 Section 8. Paragraphs (h) and (u) of subsection (3),
242 paragraph (c) of subsection (5), and paragraph (b) of subsection
243 (6) of section 627.6699, Florida Statutes, are amended, and
244 paragraph (k) is added to subsection (5) of said section, to
245 read:
246 627.6699 Employee Health Care Access Act.--
247 (3) DEFINITIONS.--As used in this section, the term:
248 (h) "Eligible employee" means an employee who works full
249 time, having a normal workweek of 25 or more hours and is paid
250 wages or a salary at least equal to the federal minimum hourly
251 wage applicable to such employee, and who has met any applicable

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252 waiting-period requirements or other requirements of this act.
253 The term includes a self-employed individual, a sole proprietor,
254 a partner of a partnership, or an independent contractor, if the
255 sole proprietor, partner, or independent contractor is included
256 as an employee under a health benefit plan of a small employer,
257 but does not include a part-time, temporary, or substitute
258 employee.
259 (u) "Self-employed individual" means an individual or sole
260 proprietor who derives his or her income from a trade or
261 business carried on by the individual or sole proprietor which
262 necessitates that the individual file federal income tax forms,
263 with supporting schedules and accompanying income reporting
264 forms, or federal income tax extensions of time to file forms
265 with the Internal Revenue Service for the most recent tax year
266 ~~results in taxable income as indicated on IRS Form 1040,~~
267 ~~schedule C or F, and which generated taxable income in one of~~
268 ~~the 2 previous years~~.
269 (5) AVAILABILITY OF COVERAGE.--
270 (c) Every small employer carrier must, as a condition of
271 transacting business in this state:
272 1. Beginning July 1, 2000, offer and issue all small
273 employer health benefit plans on a guaranteed-issue basis to
274 every eligible small employer, with 2 to 50 eligible employees,
275 that elects to be covered under such plan, agrees to make the
276 required premium payments, and satisfies the other provisions of
277 the plan. A rider for additional or increased benefits may be
278 medically underwritten and may only be added to the standard
279 health benefit plan. The increased rate charged for the

280 additional or increased benefit must be rated in accordance with
281 this section.
282 2. Beginning July 1, 2000, and until July 31, 2001, offer
283 and issue basic and standard small employer health benefit plans
284 on a guaranteed-issue basis to every eligible small employer
285 which is eligible for guaranteed renewal, has less than two
286 eligible employees, is not formed primarily for the purpose of
287 buying health insurance, elects to be covered under such plan,
288 agrees to make the required premium payments, and satisfies the
289 other provisions of the plan. A rider for additional or
290 increased benefits may be medically underwritten and may be
291 added only to the standard benefit plan. The increased rate
292 charged for the additional or increased benefit must be rated in
293 accordance with this section. For purposes of this subparagraph,
294 a person, his or her spouse, and his or her dependent children
295 shall constitute a single eligible employee if that person and
296 spouse are employed by the same small employer and either one
297 has a normal work week of less than 25 hours.
298 3. Beginning June 1, 2004 ~~August 1, 2001~~, offer and issue
299 basic and standard small employer health benefit plans on a
300 guaranteed-issue basis, during a 30-day open enrollment period
301 of June 1 through June 30 and during a 31-day open enrollment
302 period of December ~~August~~ 1 through December ~~August~~ 31 of each
303 year, to every eligible small employer, with fewer than two
304 eligible employees, which small employer is not formed primarily
305 for the purpose of buying health insurance and which elects to
306 be covered under such plan, agrees to make the required premium
307 payments, and satisfies the other provisions of the plan.

308 Coverage provided under this subparagraph shall begin 60 days
309 after ~~on October 1 of the same year as~~ the date of enrollment,
310 unless the small employer carrier and the small employer agree
311 to a different date. A rider for additional or increased
312 benefits may be medically underwritten and may only be added to
313 the standard health benefit plan. The increased rate charged for
314 the additional or increased benefit must be rated in accordance
315 with this section. For purposes of this subparagraph, a person,
316 his or her spouse, and his or her dependent children constitute
317 a single eligible employee if that person and spouse are
318 employed by the same small employer and either that person or
319 his or her spouse has a normal work week of less than 25 hours.
320 4. This paragraph does not limit a carrier's ability to
321 offer other health benefit plans to small employers if the
322 standard and basic health benefit plans are offered and
323 rejected.
324 (k) Beginning January 1, 2004, every small employer shall
325 provide, on an annual basis, information on at least three
326 different health benefit plans for employees. Nothing in this
327 paragraph shall be construed as requiring a small employer to
328 provide the health benefit plan or contribute to the cost of
329 such plan.
330 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
331 (b) For all small employer health benefit plans that are
332 subject to this section and are issued by small employer
333 carriers on or after January 1, 1994, premium rates for health
334 benefit plans subject to this section are subject to the
335 following:

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336 1. Small employer carriers must use a modified community
337 rating methodology in which the premium for each small employer
338 must be determined solely on the basis of the eligible
339 employee's and eligible dependent's gender, age, family
340 composition, tobacco use, or geographic area as determined under
341 paragraph (5)(j) and in which the premium may be adjusted as
342 permitted by this paragraph.
343 2. Rating factors related to age, gender, family
344 composition, tobacco use, or geographic location may be
345 developed by each carrier to reflect the carrier's experience.
346 The factors used by carriers are subject to department review
347 and approval.
348 3. Small employer carriers may not modify the rate for a
349 small employer for 12 months from the initial issue date or
350 renewal date, unless the composition of the group changes or
351 benefits are changed. However, a small employer carrier may
352 modify the rate one time prior to 12 months after the initial
353 issue date for a small employer who enrolls under a previously
354 issued group policy that has a common anniversary date for all
355 employers covered under the policy if:
356 a. The carrier discloses to the employer in a clear and
357 conspicuous manner the date of the first renewal and the fact
358 that the premium may increase on or after that date.
359 b. The insurer demonstrates to the department that
360 efficiencies in administration are achieved and reflected in the
361 rates charged to small employers covered under the policy.
362 4. A carrier may issue a group health insurance policy to
363 a small employer health alliance or other group association with

364 rates that reflect a premium credit for expense savings
365 attributable to administrative activities being performed by the
366 alliance or group association if such expense savings are
367 specifically documented in the insurer's rate filing and are
368 approved by the department. Any such credit may not be based on
369 different morbidity assumptions or on any other factor related
370 to the health status or claims experience of any person covered
371 under the policy. Nothing in this subparagraph exempts an
372 alliance or group association from licensure for any activities
373 that require licensure under the insurance code. A carrier
374 issuing a group health insurance policy to a small employer
375 health alliance or other group association shall allow any
376 properly licensed and appointed agent of that carrier to market
377 and sell the small employer health alliance or other group
378 association policy. Such agent shall be paid the usual and
379 customary commission paid to any agent selling the policy.
380 5. Any adjustments in rates for claims experience, health
381 status, or duration of coverage may not be charged to individual
382 employees or dependents. For a small employer's policy, such
383 adjustments may not result in a rate for the small employer
384 which deviates more than 15 percent from the carrier's approved
385 rate. Any such adjustment must be applied uniformly to the rates
386 charged for all employees and dependents of the small employer.
387 A small employer carrier may make an adjustment to a small
388 employer's renewal premium, not to exceed 10 percent annually,
389 due to the claims experience, health status, or duration of
390 coverage of the employees or dependents of the small employer.
391 Semiannually, small group carriers shall report information on

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392 forms adopted by rule by the department, to enable the
393 department to monitor the relationship of aggregate adjusted
394 premiums actually charged policyholders by each carrier to the
395 premiums that would have been charged by application of the
396 carrier's approved modified community rates. If the aggregate
397 resulting from the application of such adjustment exceeds the
398 premium that would have been charged by application of the
399 approved modified community rate by 2 ~~5~~ percent for the current
400 reporting period, the carrier shall limit the application of
401 such adjustments only to minus adjustments beginning not more
402 than 60 days after the report is sent to the department. For any
403 subsequent reporting period, if the total aggregate adjusted
404 premium actually charged does not exceed the premium that would
405 have been charged by application of the approved modified
406 community rate by 2 ~~5~~ percent, the carrier may apply both plus
407 and minus adjustments. A small employer carrier may provide a
408 credit to a small employer's premium based on administrative and
409 acquisition expense differences resulting from the size of the
410 group. Group size administrative and acquisition expense factors
411 may be developed by each carrier to reflect the carrier's
412 experience and are subject to department review and approval.
413 6. A small employer carrier rating methodology may include
414 separate rating categories for one dependent child, for two
415 dependent children, and for three or more dependent children for
416 family coverage of employees having a spouse and dependent
417 children or employees having dependent children only. A small
418 employer carrier may have fewer, but not greater, numbers of

419 categories for dependent children than those specified in this
420 subparagraph.
421 7. Small employer carriers may not use a composite rating
422 methodology to rate a small employer with fewer than 10
423 employees. For the purposes of this subparagraph, a "composite
424 rating methodology" means a rating methodology that averages the
425 impact of the rating factors for age and gender in the premiums
426 charged to all of the employees of a small employer.
427 8.a. A carrier may separate the experience of small
428 employer groups with less than 2 eligible employees from the
429 experience of small employer groups with 2-50 eligible employees
430 for purposes of determining an alternative modified community
431 rating.
432 b. If a carrier separates the experience of small employer
433 groups as provided in sub-subparagraph a., the rate to be
434 charged to small employer groups of less than 2 eligible
435 employees may not exceed 150 percent of the rate determined for
436 small employer groups of 2-50 eligible employees. However, the
437 carrier may charge excess losses of the experience pool
438 consisting of small employer groups with less than 2 eligible
439 employees to the experience pool consisting of small employer
440 groups with 2-50 eligible employees so that all losses are
441 allocated and the 150-percent rate limit on the experience pool
442 consisting of small employer groups with less than 2 eligible
443 employees is maintained. Notwithstanding s. 627.411(1), the rate
444 to be charged to a small employer group of fewer than 2 eligible
445 employees, insured as of July 1, 2002, may be up to 125 percent
446 of the rate determined for small employer groups of 2-50

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447 eligible employees for the first annual renewal and 150 percent
448 for subsequent annual renewals.
449 9. In addition to the separation allowed under sub-
450 subparagraph 8.a., a carrier may also separate the experience of
451 small employer groups of 1-50 eligible employees using a health
452 reimbursement arrangement, as defined in Internal Revenue
453 Service Notice 2002-45, 2002-28 Internal Revenue Bulletin 93,
454 and Revenue Ruling 2002-41, 2002-28 Internal Revenue Bulletin
455 75, from the experience of small employer groups of 1-50
456 eligible employees not using such a health reimbursement
457 arrangement for purposes of determining an alternative modified
458 community rating.
459 Section 9. Subsection (2) and paragraph (d) of subsection
460 (3) of section 641.31, Florida Statutes, are amended to read:
461 641.31 Health maintenance contracts.--
462 (2) The rates charged by any health maintenance
463 organization to its subscribers shall not be excessive,
464 inadequate, or unfairly discriminatory or follow a rating
465 methodology that is inconsistent, indeterminate, or ambiguous or
466 encourages misrepresentation or misunderstanding. A law
467 restricting or limiting deductibles, coinsurance, copayments, or
468 annual or lifetime maximum payments shall not apply to any
469 health maintenance organization contract offered or delivered to
470 an individual or a group of 51 or more persons that provides
471 coverage as described in s. 641.3107(5)(a)2. The department, in
472 accordance with generally accepted actuarial practice as applied
473 to health maintenance organizations, may define by rule what
474 constitutes excessive, inadequate, or unfairly discriminatory

475 rates and may require whatever information it deems necessary to
476 determine that a rate or proposed rate meets the requirements of
477 this subsection.
478 (3)
479 (d) Any change in rates charged for the contract must be
480 filed with the department not less than 30 days in advance of
481 the effective date. At the expiration of such 30 days, the rate
482 filing shall be deemed approved unless prior to such time the
483 filing has been affirmatively approved or disapproved by order
484 of the department. The approval of the filing by the department
485 constitutes a waiver of any unexpired portion of such waiting
486 period. The department may extend by not more than an additional
487 15 days the period within which it may so affirmatively approve
488 or disapprove any such filing, by giving notice of such
489 extension before expiration of the initial 30-day period. At the
490 expiration of any such period as so extended, and in the absence
491 of such prior affirmative approval or disapproval, any such
492 filing shall be deemed approved. This paragraph does not apply
493 to group health insurance policies effectuated and delivered in
494 this state insuring groups of 51 or more persons, except for
495 Medicare supplement insurance, long-term care insurance, and any
496 coverage under which the increase in claims costs over the
497 lifetime of the contract due to advancing age or duration is
498 refunded in the premium.
499 Section 10. Section 641.31075, Florida Statutes, is
500 created to read:
501 641.31075 Requirements for replacing health coverage.--Any
502 health maintenance organization that is replacing any other

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503 group health coverage with its group health maintenance coverage
504 shall comply with s. 627.666.
505 Section 11. Subsection (1) of section 641.3111, Florida
506 Statutes, is amended to read:
507 641.3111 Extension of benefits.--
508 (1) Every group health maintenance contract shall provide
509 that termination of the contract shall be without prejudice to
510 any continuous loss which commenced while the contract was in
511 force, but any extension of benefits beyond the period the
512 contract was in force may be predicated upon the continuous
513 total disability of the subscriber ~~and may be limited to payment~~
514 ~~for the treatment of a specific accident or illness incurred~~
515 ~~while the subscriber was a member~~. The extension is required
516 regardless of whether the group contract holder or other entity
517 secures replacement coverage from a new insurer or health
518 maintenance organization or foregoes the provision of coverage.
519 The required provision must provide for continuation of contract
520 benefits in connection with the treatment of a specific accident
521 or illness incurred while the contract was in effect. Such
522 extension of benefits may be limited to the occurrence of the
523 earliest of the following events:
524 (a) The expiration of 12 months.
525 (b) Such time as the member is no longer totally disabled.
526 (c) A succeeding carrier elects to provide replacement
527 coverage without limitation as to the disability condition.
528 (d) The maximum benefits payable under the contract have
529 been paid.

530 Section 12. If any provision of this act or the
531 application thereof to any person or circumstance is held
532 invalid, the invalidity shall not affect other provisions or
533 applications of the act which can be given effect without the
534 invalid provision or application, and to this end the provisions
535 of this act are declared severable.
536 Section 13. This act shall take effect upon becoming a
537 law.