180490

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/15/2016	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 275 - 779

4 and insert:

5 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571

6 do not apply to~~:~~

7 ~~(1)~~ any group insurance policy in relation to its provision

8 of ~~excepted~~ benefits described in s. 627.6513(1)-(14)

9 ~~627.6561(5)(b)~~.

10 ~~(2) Any group health insurance policy in relation to its~~

180490

11 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
12 ~~if the benefits:~~
13 ~~(a) Are provided under a separate policy, certificate, or~~
14 ~~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 its~~
17 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
18 ~~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 such~~
22 ~~benefits and any exclusion of benefits under any group policy~~
23 ~~maintained by the same policyholder; and~~
24 ~~(c) Such benefits are paid with respect to an event without~~
25 ~~regard to whether benefits are provided with respect to such an~~
26 ~~event under any group health policy maintained by the same~~
27 ~~policyholder.~~
28 ~~(4) Any group health policy in relation to its provision of~~
29 ~~excepted benefits described in s. 627.6561(5)(e), if the~~
30 ~~benefits are provided under a separate policy, certificate, or~~
31 ~~contract of insurance.~~
32 Section 13. Section 627.6513, Florida Statutes, is amended
33 to read:
34 627.6513 Scope.—Section 641.312 and the provisions of the
35 Employee Retirement Income Security Act of 1974, as implemented
36 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
37 apply to all group health insurance policies issued under this
38 part. This section does not apply to a group health insurance
39 policy that is subject to the Subscriber Assistance Program in

180490

40 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
41 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
42 (1) Coverage only for accident insurance, or disability
43 income insurance, or any combination thereof.
44 (2) Coverage issued as a supplement to liability insurance.
45 (3) Liability insurance, including general liability
46 insurance and automobile liability insurance.
47 (4) Workers' compensation or similar insurance.
48 (5) Automobile medical payment insurance.
49 (6) Credit-only insurance.
50 (7) Coverage for onsite medical clinics, including prepaid
51 health clinics under part II of chapter 641.
52 (8) Other similar insurance coverage, specified in rules
53 adopted by the commission, under which benefits for medical care
54 are secondary or incidental to other insurance benefits. To the
55 extent possible, such rules must be consistent with regulations
56 adopted by the United States Department of Health and Human
57 Services.
58 (9) Limited scope dental or vision benefits, if offered
59 separately.
60 (10) Benefits for long-term care, nursing home care, home
61 health care, or community-based care, or any combination
62 thereof, if offered separately.
63 (11) Other similar, limited benefits, if offered
64 separately, as specified in rules adopted by the commission.
65 (12) Coverage only for a specified disease or illness, if
66 offered as independent, noncoordinated benefits.
67 (13) Hospital indemnity or other fixed indemnity insurance,
68 if offered as independent, noncoordinated benefits.

180490

69 (14) Benefits provided through a Medicare supplemental
70 health insurance policy, as defined under s. 1882(g)(1) of the
71 Social Security Act, coverage supplemental to the coverage
72 provided under 10 U.S.C. chapter 55, and similar supplemental
73 coverage provided to coverage under a group health plan, which
74 are offered as a separate insurance policy and as independent,
75 noncoordinated benefits.
76 Section 14. Section 627.6561, Florida Statutes, is amended
77 to read:
78 627.6561 Preexisting conditions.—
79 (1) As used in this section, the term:
80 (a) "Enrollment date" means, with respect to an individual
81 covered under a group health policy, the date of enrollment of
82 the individual in the plan or coverage or, if earlier, the first
83 day of the waiting period of such enrollment.
84 (b) "Late enrollee" means, with respect to coverage under a
85 group health policy, a participant or beneficiary who enrolls
86 under the policy other than during:
87 1. The first period in which the individual is eligible to
88 enroll under the policy.
89 2. A special enrollment period, as provided under s.
90 627.65615.
91 (c) "Waiting period" means, with respect to a group health
92 policy and an individual who is a potential participant or
93 beneficiary of the policy, the period that must pass with
94 respect to the individual before the individual is eligible to
95 be covered for benefits under the terms of the policy.
96 (2) Subject to the exceptions specified in subsection (4),
97 an insurer that offers group health insurance coverage may, with

180490

98 respect to a participant or beneficiary, impose a preexisting
99 condition exclusion only if:
100 (a) Such exclusion relates to a physical or mental
101 condition, regardless of the cause of the condition, for which
102 medical advice, diagnosis, care, or treatment was recommended or
103 received within the 6-month period ending on the enrollment
104 date;
105 (b) Such exclusion extends for a period of not more than 12
106 months, or 18 months in the case of a late enrollee, after the
107 enrollment date; and
108 (c) The period of any such preexisting condition exclusion
109 is reduced by the aggregate of the periods of creditable
110 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
111 applicable to the participant or beneficiary as of the
112 enrollment date.
113 (3) Genetic information may not be treated as a condition
114 described in paragraph (2)(a) in the absence of a diagnosis of
115 the condition related to such information.
116 (4)(a) Subject to paragraph (b), an insurer that offers
117 group health insurance coverage may not impose any preexisting
118 condition exclusion in the case of:
119 1. An individual who, as of the last day of the 30-day
120 period beginning with the date of birth, is covered under
121 creditable coverage.
122 2. A child who is adopted or placed for adoption before
123 attaining 18 years of age and who, as of the last day of the 30-
124 day period beginning on the date of the adoption or placement
125 for adoption, is covered under creditable coverage. This
126 provision does not apply to coverage before the date of such

180490

127 adoption or placement for adoption.
128 3. Pregnancy.
129 (b) Subparagraphs 1. and 2. do not apply to an individual
130 after the end of the first 63-day period during all of which the
131 individual was not covered under any creditable coverage.
132 ~~(5)(a) The term, “creditable coverage,” means, with respect~~
133 ~~to an individual, coverage of the individual under any of the~~
134 ~~following:~~
135 ~~1. A group health plan, as defined in s. 2791 of the Public~~
136 ~~Health Service Act.~~
137 ~~2. Health insurance coverage consisting of medical care,~~
138 ~~provided directly, through insurance or reimbursement, or~~
139 ~~otherwise and including terms and services paid for as medical~~
140 ~~care, under any hospital or medical service policy or~~
141 ~~certificate, hospital or medical service plan contract, or~~
142 ~~health maintenance contract offered by a health insurance~~
143 ~~issuer.~~
144 ~~3. Part A or part B of Title XVIII of the Social Security~~
145 ~~Act.~~
146 ~~4. Title XIX of the Social Security Act, other than~~
147 ~~coverage consisting solely of benefits under s. 1928.~~
148 ~~5. Chapter 55 of Title 10, United States Code.~~
149 ~~6. A medical care program of the Indian Health Service or~~
150 ~~of a tribal organization.~~
151 ~~7. The Florida Comprehensive Health Association or another~~
152 ~~state health benefit risk pool.~~
153 ~~8. A health plan offered under chapter 89 of Title 5,~~
154 ~~United States Code.~~
155 ~~9. A public health plan as defined by rules adopted by the~~

180490

156 ~~commission. To the greatest extent possible, such rules must be~~
157 ~~consistent with regulations adopted by the United States~~
158 ~~Department of Health and Human Services.~~
159 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
160 ~~Act (22 U.S.C. s. 2504(e)).~~
161 ~~(b) Creditable coverage does not include coverage that~~
162 ~~consists solely of one or more or any combination thereof of the~~
163 ~~following excepted benefits:~~
164 ~~1. Coverage only for accident, or disability income~~
165 ~~insurance, or any combination thereof.~~
166 ~~2. Coverage issued as a supplement to liability insurance.~~
167 ~~3. Liability insurance, including general liability~~
168 ~~insurance and automobile liability insurance.~~
169 ~~4. Workers' compensation or similar insurance.~~
170 ~~5. Automobile medical payment insurance.~~
171 ~~6. Credit-only insurance.~~
172 ~~7. Coverage for onsite medical clinics, including prepaid~~
173 ~~health clinics under part II of chapter 641.~~
174 ~~8. Other similar insurance coverage, specified in rules~~
175 ~~adopted by the commission, under which benefits for medical care~~
176 ~~are secondary or incidental to other insurance benefits. To the~~
177 ~~extent possible, such rules must be consistent with regulations~~
178 ~~adopted by the United States Department of Health and Human~~
179 ~~Services.~~
180 ~~(c) The following benefits are not subject to the~~
181 ~~creditable coverage requirements, if offered separately:~~
182 ~~1. Limited scope dental or vision benefits.~~
183 ~~2. Benefits for long-term care, nursing home care, home~~
184 ~~health care, community-based care, or any combination thereof.~~

180490

185 ~~3. Such other similar, limited benefits as are specified in~~
186 ~~rules adopted by the commission.~~
187 ~~(d) The following benefits are not subject to creditable~~
188 ~~coverage requirements if offered as independent, noncoordinated~~
189 ~~benefits:~~
190 ~~1. Coverage only for a specified disease or illness.~~
191 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
192 ~~(e) Benefits provided through a Medicare supplemental~~
193 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~
194 ~~Security Act, coverage supplemental to the coverage provided~~
195 ~~under chapter 55 of Title 10, United States Code, and similar~~
196 ~~supplemental coverage provided to coverage under a group health~~
197 ~~plan are not considered creditable coverage if offered as a~~
198 ~~separate insurance policy.~~
199 ~~(6)(a) A period of creditable coverage may not be counted,~~
200 ~~with respect to enrollment of an individual under a group health~~
201 ~~plan, if, after such period and before the enrollment date,~~
202 ~~there was a 63-day period during all of which the individual was~~
203 ~~not covered under any creditable coverage.~~
204 ~~(b) Any period during which an individual is in a waiting~~
205 ~~period for any coverage under a group health plan or for group~~
206 ~~health insurance coverage may not be taken into account in~~
207 ~~determining the 63-day period under paragraph (a) or paragraph~~
208 ~~(4)(b).~~
209 ~~(7)(a) Except as otherwise provided under paragraph (b), an~~
210 ~~insurer shall count a period of creditable coverage without~~
211 ~~regard to the specific benefits covered under the period.~~
212 ~~(b) An insurer may elect to count, as creditable coverage,~~
213 ~~coverage of benefits within each of several classes or~~

180490

214 ~~categories of benefits specified in rules adopted by the~~
215 ~~commission rather than as provided under paragraph (a). To the~~
216 ~~extent possible, such rules must be consistent with regulations~~
217 ~~adopted by the United States Department of Health and Human~~
218 ~~Services. Such election shall be made on a uniform basis for all~~
219 ~~participants and beneficiaries. Under such election, an insurer~~
220 ~~shall count a period of creditable coverage with respect to any~~
221 ~~class or category of benefits if any level of benefits is~~
222 ~~covered within such class or category.~~
223 ~~(c) In the case of an election with respect to an insurer~~
224 ~~under paragraph (b), the insurer shall:~~
225 ~~1. Prominently state in 10-point type or larger in any~~
226 ~~disclosure statements concerning the policy, and state to each~~
227 ~~certificateholder at the time of enrollment under the policy,~~
228 ~~that the insurer has made such election; and~~
229 ~~2. Include in such statements a description of the effect~~
230 ~~of this election.~~
231 ~~(8)(a) Periods of creditable coverage with respect to an~~
232 ~~individual shall be established through presentation of~~
233 ~~certifications described in this subsection or in such other~~
234 ~~manner as is specified in rules adopted by the commission. To~~
235 ~~the extent possible, such rules must be consistent with~~
236 ~~regulations adopted by the United States Department of Health~~
237 ~~and Human Services.~~
238 ~~(b) An insurer that offers group health insurance coverage~~
239 ~~shall provide the certification described in paragraph (a):~~
240 ~~1. At the time an individual ceases to be covered under the~~
241 ~~plan or otherwise becomes covered under a COBRA continuation~~
242 ~~provision or continuation pursuant to s. 627.6692.~~

180490

243 ~~2. In the case of an individual becoming covered under a~~
244 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
245 ~~time the individual ceases to be covered under such a provision.~~
246 ~~3. Upon the request on behalf of an individual made not~~
247 ~~later than 24 months after the date of cessation of the coverage~~
248 ~~described in this paragraph.~~
249
250 ~~The certification under subparagraph 1. may be provided, to the~~
251 ~~extent practicable, at a time consistent with notices required~~
252 ~~under any applicable COBRA continuation provision or~~
253 ~~continuation pursuant to s. 627.6692.~~
254 ~~(c) The certification described in this section is a~~
255 ~~written certification that must include:~~
256 ~~1. The period of creditable coverage of the individual~~
257 ~~under the policy and the coverage, if any, under such COBRA~~
258 ~~continuation provision or continuation pursuant to s. 627.6692;~~
259 ~~and~~
260 ~~2. The waiting period, if any, imposed with respect to the~~
261 ~~individual for any coverage under such policy.~~
262 ~~(d) In the case of an election described in subsection (7)~~
263 ~~by an insurer, if the insurer enrolls an individual for coverage~~
264 ~~under the plan and the individual provides a certification of~~
265 ~~coverage of the individual, as provided in this subsection:~~
266 ~~1. Upon request of such insurer, the insurer that issued~~
267 ~~the certification provided by the individual shall promptly~~
268 ~~disclose to such requesting plan or insurer information on~~
269 ~~coverage of classes and categories of health benefits available~~
270 ~~under such insurer’s plan or coverage.~~
271 ~~2. Such insurer may charge the requesting insurer for the~~

180490

272 ~~reasonable cost of disclosing such information.~~
273 ~~(c) The commission shall adopt rules to prevent an~~
274 ~~insurer's failure to provide information under this subsection~~
275 ~~with respect to previous coverage of an individual from~~
276 ~~adversely affecting any subsequent coverage of the individual~~
277 ~~under another group health plan or health insurance coverage. To~~
278 ~~the greatest extent possible, such rules must be consistent with~~
279 ~~regulations adopted by the United States Department of Health~~
280 ~~and Human Services.~~
281 ~~(9)(a) Except as provided in paragraph (b), no period~~
282 ~~before July 1, 1996, shall be taken into account in determining~~
283 ~~creditable coverage.~~
284 ~~(b) The commission shall adopt rules that provide a process~~
285 ~~whereby individuals who need to establish creditable coverage~~
286 ~~for periods before July 1, 1996, and who would have such~~
287 ~~coverage credited but for paragraph (a), may be given credit for~~
288 ~~creditable coverage for such periods through the presentation of~~
289 ~~documents or other means. To the greatest extent possible, such~~
290 ~~rules must be consistent with regulations adopted by the United~~
291 ~~States Department of Health and Human Services.~~
292 ~~(10) Except as otherwise provided in this subsection,~~
293 ~~paragraph (8)(b) applies to events that occur on or after July~~
294 ~~1, 1996.~~
295 ~~(a) In no case is a certification required to be provided~~
296 ~~under paragraph (8)(b) prior to June 1, 1997.~~
297 ~~(b) In the case of an event that occurred on or after July~~
298 ~~1, 1996, and before October 1, 1996, a certification is not~~
299 ~~required to be provided under paragraph (8)(b), unless an~~
300 ~~individual, with respect to whom the certification is required~~

180490

301 ~~to be made, requests such certification in writing.~~
302 ~~(11) In the case of an individual who seeks to establish~~
303 ~~creditable coverage for any period for which certification is~~
304 ~~not required because it relates to an event that occurred before~~
305 ~~July 1, 1996:~~
306 ~~(a) The individual may present other creditable coverage in~~
307 ~~order to establish the period of creditable coverage.~~
308 ~~(b) An insurer is not subject to any penalty or enforcement~~
309 ~~action with respect to the insurer's crediting, or not~~
310 ~~crediting, such coverage if the insurer has sought to comply in~~
311 ~~good faith with applicable provisions of this section.~~
312 ~~(12) For purposes of subsection (9), any plan amendment~~
313 ~~made pursuant to a collective bargaining agreement relating to~~
314 ~~the plan which amends the plan solely to conform to any~~
315 ~~requirement of this section may not be treated as a termination~~
316 ~~of such collective bargaining agreement.~~
317 ~~(13) This section does not apply to any health insurance~~
318 ~~coverage in relation to its provision of excepted benefits~~
319 ~~described in paragraph (5)(b).~~
320 ~~(14) This section does not apply to any health insurance~~
321 ~~coverage in relation to its provision of excepted benefits~~
322 ~~described in paragraphs (5)(c), (d), or (e), if the benefits are~~
323 ~~provided under a separate policy, certificate, or contract of~~
324 ~~insurance.~~
325 ~~(15) This section applies to health insurance coverage~~
326 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
327 ~~1997.~~
328 Section 15. Subsection (3) of section 627.6562, Florida
329 Statutes, is amended to read:

180490

330 627.6562 Dependent coverage.—
331 (3) If, pursuant to subsection (2), a child is provided
332 coverage under the parent's policy after the end of the calendar
333 year in which the child reaches age 25 and coverage for the
334 child is subsequently terminated, the child is not eligible to
335 be covered under the parent's policy unless the child was
336 continuously covered by other creditable coverage without a gap
337 in coverage of more than 63 days.
338 (a) For the purposes of this subsection, the term
339 "creditable coverage" means, with respect to an individual,
340 coverage of the individual under any of the following: ~~has the~~
341 ~~same meaning as provided in s. 627.6561(5).~~
342 1. A group health plan, as defined in s. 2791 of the Public
343 Health Service Act.
344 2. Health insurance coverage consisting of medical care
345 provided directly through insurance or reimbursement or
346 otherwise, and including terms and services paid for as medical
347 care, under any hospital or medical service policy or
348 certificate, hospital or medical service plan contract, or
349 health maintenance contract offered by a health insurance
350 issuer.
351 3. Part A or part B of Title XVIII of the Social Security
352 Act.
353 4. Title XIX of the Social Security Act, other than
354 coverage consisting solely of benefits under s. 1928.
355 5. Title 10 U.S.C. chapter 55.
356 6. A medical care program of the Indian Health Service or
357 of a tribal organization.
358 7. The Florida Comprehensive Health Association or another

180490

359 state health benefit risk pool.
360 8. A health plan offered under 5 U.S.C. chapter 89.
361 9. A public health plan as defined by rules adopted by the
362 commission. To the greatest extent possible, such rules must be
363 consistent with regulations adopted by the United States
364 Department of Health and Human Services.
365 10. A health benefit plan under s. 5(e) of the Peace Corps
366 Act, 22 U.S.C. s. 2504(e).
367 (b) Creditable coverage does not include coverage that
368 consists of one or more, or any combination thereof, of the
369 following excepted benefits:
370 1. Coverage only for accident insurance, or disability
371 income insurance, or any combination thereof.
372 2. Coverage issued as a supplement to liability insurance.
373 3. Liability insurance, including general liability
374 insurance and automobile liability insurance.
375 4. Workers' compensation or similar insurance.
376 5. Automobile medical payment insurance.
377 6. Credit-only insurance.
378 7. Coverage for onsite medical clinics, including prepaid
379 health clinics under part II of chapter 641.
380 8. Other similar insurance coverage specified in rules
381 adopted by the commission under which benefits for medical care
382 are secondary or incidental to other insurance benefits. To the
383 extent possible, such rules must be consistent with regulations
384 adopted by the United States Department of Health and Human
385 Services.
386 (c) The following benefits are not subject to the
387 creditable coverage requirements, if offered separately:

180490

388 1. Limited scope dental or vision benefits.
389 2. Benefits for long-term care, nursing home care, home
390 health care, community-based care, or any combination thereof.
391 3. Other similar, limited benefits specified in rules
392 adopted by the commission.
393 (d) The following benefits are not subject to creditable
394 coverage requirements if offered as independent, noncoordinated
395 benefits:
396 1. Coverage only for a specified disease or illness.
397 2. Hospital indemnity or other fixed indemnity insurance.
398 (e) Benefits provided through a Medicare supplemental
399 health insurance policy, as defined under s. 1882(g)(1) of the
400 Social Security Act, coverage supplemental to the coverage
401 provided under 10 U.S.C. chapter 55, and similar supplemental
402 coverage provided to coverage under a group health plan are not
403 considered creditable coverage if offered as a separate
404 insurance policy.
405 Section 16. Subsection (1) of section 627.65626, Florida
406 Statutes, is amended to read:
407 627.65626 Insurance rebates for healthy lifestyles.—
408 (1) Any rate, rating schedule, or rating manual for a
409 health insurance policy that provides creditable coverage as
410 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
411 shall provide for an appropriate rebate of premiums paid in the
412 last policy year, contract year, or calendar year when the
413 majority of members of a health plan have enrolled and
414 maintained participation in any health wellness, maintenance, or
415 improvement program offered by the group policyholder and health
416 plan. The rebate may be based upon premiums paid in the last

180490

417 calendar year or policy year. The group must provide evidence of
418 demonstrative maintenance or improvement of the enrollees'
419 health status as determined by assessments of agreed-upon health
420 status indicators between the policyholder and the health
421 insurer, including, but not limited to, reduction in weight,
422 body mass index, and smoking cessation. The group or health
423 insurer may contract with a third-party administrator to
424 assemble and report the health status required in this
425 subsection between the policyholder and the health insurer. Any
426 rebate provided by the health insurer is presumed to be
427 appropriate unless credible data demonstrates otherwise, or
428 unless the rebate program requires the insured to incur costs to
429 qualify for the rebate which equal or exceed the value of the
430 rebate, but the rebate may not exceed 10 percent of paid
431 premiums.
432 Section 17. Paragraphs (e) and (l) of subsection (3) and
433 paragraph (d) of subsection (5) of section 627.6699, Florida
434 Statutes, are amended to read:
435 627.6699 Employee Health Care Access Act.—
436 (3) DEFINITIONS.—As used in this section, the term:
437 (e) "Creditable coverage" has the same meaning as provided
438 ascribed in s. 627.6562(3) 627.6561.
439 (l) "Late enrollee" means an eligible employee or dependent
440 who, with respect to coverage under a group health policy, is a
441 participant or beneficiary who enrolls under the policy other
442 than during:
443 1. The first period in which the individual is eligible to
444 enroll under the policy.
445 2. A special enrollment period, as provided under s.

180490

446 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
447 (5) AVAILABILITY OF COVERAGE.—
448 (d) A health benefit plan covering small employers, issued
449 or renewed on or after January 1, 1994, must comply with the
450 following conditions:
451 1. All health benefit plans must be offered and issued on a
452 guaranteed-issue basis. Additional or increased benefits may
453 only be offered by riders.
454 ~~2. Paragraph (c) applies to health benefit plans issued to~~
455 ~~a small employer who has two or more eligible employees and to~~
456 ~~health benefit plans that are issued to a small employer who has~~
457 ~~fewer than two eligible employees and that cover an employee who~~
458 ~~has had creditable coverage continually to a date not more than~~
459 ~~63 days before the effective date of the new coverage.~~
460 2.~~3.~~ For health benefit plans that are issued to a small
461 employer who has fewer than two employees and that cover an
462 employee who has not been continually covered by creditable
463 coverage within 63 days before the effective date of the new
464 coverage, preexisting condition provisions must not exclude
465 coverage for a period beyond 24 months following the employee’s
466 effective date of coverage and may relate only to:
467 a. Conditions that, during the 24-month period immediately
468 preceding the effective date of coverage, had manifested
469 themselves in such a manner as would cause an ordinarily prudent
470 person to seek medical advice, diagnosis, care, or treatment or
471 for which medical advice, diagnosis, care, or treatment was
472 recommended or received; or
473 b. A pregnancy existing on the effective date of coverage.
474 Section 18. Subsection (1) and paragraph (c) of subsection

180490

475 (2) of section 627.6741, Florida Statutes, are amended to read:
476 627.6741 Issuance, cancellation, nonrenewal, and
477 replacement.—
478 (1)(a) An insurer issuing Medicare supplement policies in
479 this state shall offer the opportunity of enrolling in a
480 Medicare supplement policy, without conditioning the issuance or
481 effectiveness of the policy on, and without discriminating in
482 the price of the policy based on, the medical or health status
483 or receipt of health care by the individual:
484 1. To any individual who is 65 years of age or older, or
485 under 65 years of age and eligible for Medicare by reason of
486 disability or end-stage renal disease, and who resides in this
487 state, upon the request of the individual during the 6-month
488 period beginning with the first month in which the individual
489 has attained 65 years of age and is enrolled in Medicare Part B,
490 or is eligible for Medicare by reason of a disability or end-
491 stage renal disease, and is enrolled in Medicare Part B; or
492 2. To any individual who is 65 years of age or older, or
493 under 65 years of age and eligible for Medicare by reason of a
494 disability or end-stage renal disease, who is enrolled in
495 Medicare Part B, and who resides in this state, upon the request
496 of the individual during the 2-month period following
497 termination of coverage under a group health insurance policy.
498 (b) The 6-month period to enroll in a Medicare supplement
499 policy for an individual who is under 65 years of age and is
500 eligible for Medicare by reason of disability or end-stage renal
501 disease and otherwise eligible under subparagraph (a)1. or
502 subparagraph (a)2. and first enrolled in Medicare Part B before
503 October 1, 2009, begins on October 1, 2009.

180490

504 (c) A company that has offered Medicare supplement policies
505 to individuals under 65 years of age who are eligible for
506 Medicare by reason of disability or end-stage renal disease
507 before October 1, 2009, may, for one time only, effect a rate
508 schedule change that redefines the age bands of the premium
509 classes without activating the period of discontinuance required
510 by s. 627.410(6)(e)2.
511 (d) As a part of an insurer’s rate filings, before and
512 including the insurer’s first rate filing for a block of policy
513 forms in 2015, notwithstanding the provisions of s.
514 627.410(6)(e)3., an insurer shall consider the experience of the
515 policies or certificates for the premium classes including
516 individuals under 65 years of age and eligible for Medicare by
517 reason of disability or end-stage renal disease separately from
518 the balance of the block so as not to affect the other premium
519 classes. For filings in such time period only, credibility of
520 that experience shall be as follows: if a block of policy forms
521 has 1,250 or more policies or certificates in force in the age
522 band including ages under 65 years of age, full or 100-percent
523 credibility shall be given to the experience; and if fewer than
524 250 policies or certificates are in force, no or zero-percent
525 credibility shall be given. Linear interpolation shall be used
526 for in-force amounts between the low and high values. Florida-
527 only experience shall be used if it is 100-percent credible. If
528 Florida-only experience is not 100-percent credible, a
529 combination of Florida-only and nationwide experience shall be
530 used. If Florida-only experience is zero-percent credible,
531 nationwide experience shall be used. The insurer may file its
532 initial rates and any rate adjustment based upon the experience

180490

533 of these policies or certificates or based upon expected claim
534 experience using experience data of the same company, other
535 companies in the same or other states, or using data publicly
536 available from the Centers for Medicaid and Medicare Services if
537 the insurer's combined Florida and nationwide experience is not
538 100-percent credible, separate from the balance of all other
539 Medicare supplement policies.
540
541 A Medicare supplement policy issued to an individual under
542 subparagraph (a)1. or subparagraph (a)2. may not exclude
543 benefits based on a preexisting condition if the individual has
544 a continuous period of creditable coverage, as defined in s.
545 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
546 application for coverage.
547 (2) For both individual and group Medicare supplement
548 policies:
549 (c) If a Medicare supplement policy or certificate replaces
550 another Medicare supplement policy or certificate or creditable
551 coverage as defined in s. 627.6562(3) ~~627.6561(5)~~, the replacing
552 insurer shall waive any time periods applicable to preexisting
553 conditions, waiting periods, elimination periods, and
554 probationary periods in the new Medicare supplement policy for
555 similar benefits to the extent such time was spent under the
556 original policy~~, subject to the requirements of s. 627.6561(6)-~~
557 ~~(11)~~.
558 Section 19. Subsection (2) and paragraph (a) of subsection
559 (40) of section 641.31, Florida Statutes, are amended to read:
560 641.31 Health maintenance contracts.—
561 (2) The rates charged by any health maintenance

180490

562 organization to its subscribers shall not be excessive,
563 inadequate, or unfairly discriminatory or follow a rating
564 methodology that is inconsistent, indeterminate, or ambiguous or
565 encourages misrepresentation or misunderstanding. ~~A law~~
566 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
567 ~~annual or lifetime maximum payments shall not apply to any~~
568 ~~health maintenance organization contract that provides coverage~~
569 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
570 ~~individual or a group of 51 or more persons.~~ The commission, in
571 accordance with generally accepted actuarial practice as applied
572 to health maintenance organizations, may define by rule what
573 constitutes excessive, inadequate, or unfairly discriminatory
574 rates and may require whatever information it deems necessary to
575 determine that a rate or proposed rate meets the requirements of
576 this subsection.
577 (40)(a) Any group rate, rating schedule, or rating manual
578 for a health maintenance organization policy, which provides
579 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
580 filed with the office shall provide for an appropriate rebate of
581 premiums paid in the last policy year, contract year, or
582 calendar year when the majority of members of a health plan are
583 enrolled in and have maintained participation in any health
584 wellness, maintenance, or improvement program offered by the
585 group contract holder. The group must provide evidence of
586 demonstrative maintenance or improvement of his or her health
587 status as determined by assessments of agreed-upon health status
588 indicators between the group and the health insurer, including,
589 but not limited to, reduction in weight, body mass index, and
590 smoking cessation. Any rebate provided by the health maintenance

180490

591 organization is presumed to be appropriate unless credible data
592 demonstrates otherwise, or unless the rebate program requires
593 the insured to incur costs to qualify for the rebate which
594 equals or exceeds the value of the rebate but the rebate may not
595 exceed 10 percent of paid premiums.
596 Section 20. Section 641.31071, Florida Statutes, is amended
597 to read:
598 641.31071 Preexisting conditions.—
599 (1) As used in this section, the term:
600 (a) "Enrollment date" means, with respect to an individual
601 covered under a group health maintenance organization contract,
602 the date of enrollment of the individual in the plan or coverage
603 or, if earlier, the first day of the waiting period of such
604 enrollment.
605 (b) "Late enrollee" means, with respect to coverage under a
606 group health maintenance organization contract, a participant or
607 beneficiary who enrolls under the contract other than during:
608 1. The first period in which the individual is eligible to
609 enroll under the plan.
610 2. A special enrollment period, as provided under s.
611 641.31072.
612 (c) "Waiting period" means, with respect to a group health
613 maintenance organization contract and an individual who is a
614 potential participant or beneficiary under the contract, the
615 period that must pass with respect to the individual before the
616 individual is eligible to be covered for benefits under the
617 terms of the contract.
618 (2) Subject to the exceptions specified in subsection (4),
619 a health maintenance organization that offers group coverage,

180490

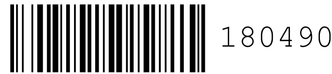
620 may, with respect to a participant or beneficiary, impose a
621 preexisting condition exclusion only if:
622 (a) Such exclusion relates to a physical or mental
623 condition, regardless of the cause of the condition, for which
624 medical advice, diagnosis, care, or treatment was recommended or
625 received within the 6-month period ending on the enrollment
626 date;
627 (b) Such exclusion extends for a period of not more than 12
628 months, or 18 months in the case of a late enrollee, after the
629 enrollment date; and
630 (c) The period of any such preexisting condition exclusion
631 is reduced by the aggregate of the periods of creditable
632 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
633 applicable to the participant or beneficiary as of the
634 enrollment date.
635 (3) Genetic information shall not be treated as a condition
636 described in paragraph (2)(a) in the absence of a diagnosis of
637 the condition related to such information.
638 (4)(a) Subject to paragraph (b), a health maintenance
639 organization that offers group coverage may not impose any
640 preexisting condition exclusion in the case of:
641 1. An individual who, as of the last day of the 30-day
642 period beginning with the date of birth, is covered under
643 creditable coverage.
644 2. A child who is adopted or placed for adoption before
645 attaining 18 years of age and who, as of the last day of the 30-
646 day period beginning on the date of the adoption or placement
647 for adoption, is covered under creditable coverage. This
648 provision shall not apply to coverage before the date of such

180490

649 adoption or placement for adoption.
650 3. Pregnancy.
651 (b) Subparagraphs (a)1. and 2. do not apply to an
652 individual after the end of the first 63-day period during all
653 of which the individual was not covered under any creditable
654 coverage.
655 ~~(5)(a) The term "creditable coverage" means, with respect~~
656 ~~to an individual, coverage of the individual under any of the~~
657 ~~following:~~
658 ~~1. A group health plan, as defined in s. 2791 of the Public~~
659 ~~Health Service Act.~~
660 ~~2. Health insurance coverage consisting of medical care,~~
661 ~~provided directly, through insurance or reimbursement or~~
662 ~~otherwise, and including terms and services paid for as medical~~
663 ~~care, under any hospital or medical service policy or~~
664 ~~certificate, hospital or medical service plan contract, or~~
665 ~~health maintenance contract offered by a health insurance~~
666 ~~issuer.~~
667 ~~3. Part A or part B of Title XVIII of the Social Security~~
668 ~~Act.~~
669 ~~4. Title XIX of the Social Security Act, other than~~
670 ~~coverage consisting solely of benefits under s. 1928.~~
671 ~~5. Chapter 55 of Title 10, United States Code.~~
672 ~~6. A medical care program of the Indian Health Service or~~
673 ~~of a tribal organization.~~
674 ~~7. The Florida Comprehensive Health Association or another~~
675 ~~state health benefit risk pool.~~
676 ~~8. A health plan offered under chapter 89 of Title 5,~~
677 ~~United States Code.~~

180490

678 ~~9. A public health plan as defined by rule of the~~
679 ~~commission. To the greatest extent possible, such rules must be~~
680 ~~consistent with regulations adopted by the United States~~
681 ~~Department of Health and Human Services.~~
682 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
683 ~~Act (22 U.S.C. s. 2504(e)).~~
684 ~~(b) Creditable coverage does not include coverage that~~
685 ~~consists solely of one or more or any combination thereof of the~~
686 ~~following excepted benefits:~~
687 ~~1. Coverage only for accident, or disability income~~
688 ~~insurance, or any combination thereof.~~
689 ~~2. Coverage issued as a supplement to liability insurance.~~
690 ~~3. Liability insurance, including general liability~~
691 ~~insurance and automobile liability insurance.~~
692 ~~4. Workers' compensation or similar insurance.~~
693 ~~5. Automobile medical payment insurance.~~
694 ~~6. Credit-only insurance.~~
695 ~~7. Coverage for onsite medical clinics.~~
696 ~~8. Other similar insurance coverage, specified in rules~~
697 ~~adopted by the commission, under which benefits for medical care~~
698 ~~are secondary or incidental to other insurance benefits. To the~~
699 ~~greatest extent possible, such rules must be consistent with~~
700 ~~regulations adopted by the United States Department of Health~~
701 ~~and Human Services.~~
702 ~~(c) The following benefits are not subject to the~~
703 ~~creditable coverage requirements, if offered separately:~~
704 ~~1. Limited scope dental or vision benefits.~~
705 ~~2. Benefits or long-term care, nursing home care, home~~
706 ~~health care, community-based care, or any combination of these.~~


180490

707 ~~3. Such other similar, limited benefits as are specified in~~
708 ~~rules adopted by the commission. To the greatest extent~~
709 ~~possible, such rules must be consistent with regulations adopted~~
710 ~~by the United States Department of Health and Human Services.~~
711 ~~(d) The following benefits are not subject to creditable~~
712 ~~coverage requirements if offered as independent, noncoordinated~~
713 ~~benefits:~~
714 ~~1. Coverage only for a specified disease or illness.~~
715 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
716 ~~(e) Benefits provided through Medicare supplemental health~~
717 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
718 ~~Act, coverage supplemental to the coverage provided under~~
719 ~~chapter 55 of Title 10, United States Code, and similar~~
720 ~~supplemental coverage provided to coverage under a group health~~
721 ~~plan are not considered creditable coverage if offered as a~~
722 ~~separate insurance policy.~~
723 ~~(6)(a) A period of creditable coverage may not be counted,~~
724 ~~with respect to enrollment of an individual under a group health~~
725 ~~maintenance organization contract, if, after such period and~~
726 ~~before the enrollment date, there was a 63-day period during all~~
727 ~~of which the individual was not covered under any creditable~~
728 ~~coverage.~~
729 ~~(b) Any period during which an individual is in a waiting~~
730 ~~period, or in an affiliation period as defined in subsection~~
731 ~~(9), for any coverage under a group health maintenance~~
732 ~~organization contract may not be taken into account in~~
733 ~~determining the 63-day period under paragraph (a) or paragraph~~
734 ~~(4)(b).~~
735 ~~(7)(a) Except as otherwise provided under paragraph (b), a~~

180490

736 health maintenance organization shall count a period of
737 creditable coverage without regard to the specific benefits
738 covered under the period.
739 (b) A health maintenance organization may elect to count as
740 creditable coverage, coverage of benefits within each of several
741 classes or categories of benefits specified in rules adopted by
742 the commission rather than as provided under paragraph (a). Such
743 election shall be made on a uniform basis for all participants
744 and beneficiaries. Under such election, a health maintenance
745 organization shall count a period of creditable coverage with
746 respect to any class or category of benefits if any level of
747 benefits is covered within such class or category.
748 (c) In the case of an election with respect to a health
749 maintenance organization under paragraph (b), the organization
750 shall:
751 1. Prominently state in 10-point type or larger in any
752 disclosure statements concerning the contract, and state to each
753 enrollee at the time of enrollment under the contract, that the
754 organization has made such election; and
755 2. Include in such statements a description of the effect
756 of this election.
757 (8)(a) Periods of creditable coverage with respect to an
758 individual shall be established through presentation of
759 certifications described in this subsection or in such other
760 manner as may be specified in rules adopted by the commission.
761 (b) A health maintenance organization that offers group
762 coverage shall provide the certification described in paragraph
763 (a):
764 1. At the time an individual ceases to be covered under the

180490

765 ~~plan or otherwise becomes covered under a COBRA continuation~~
766 ~~provision or continuation pursuant to s. 627.6692.~~
767 ~~2. In the case of an individual becoming covered under a~~
768 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
769 ~~time the individual ceases to be covered under such a provision.~~
770 ~~3. Upon the request on behalf of an individual made not~~
771 ~~later than 24 months after the date of cessation of the coverage~~
772 ~~described in this paragraph.~~
773
774 ~~The certification under subparagraph 1. may be provided, to the~~
775 ~~extent practicable, at a time consistent with notices required~~
776 ~~under any applicable COBRA continuation provision or~~
777 ~~continuation pursuant to s. 627.6692.~~
778 ~~(c) The certification is a written certification of:~~
779 ~~1. The period of creditable coverage of the individual~~
780 ~~under the contract and the coverage, if any, under such COBRA~~
781 ~~continuation provision or continuation pursuant to s. 627.6692;~~
782 ~~and~~
783 ~~2. The waiting period, if any, imposed with respect to the~~
784 ~~individual for any coverage under such contract.~~
785 ~~(d) In the case of an election described in subsection (7)~~
786 ~~by a health maintenance organization, if the organization~~
787 ~~enrolls an individual for coverage under the plan and the~~
788 ~~individual provides a certification of coverage of the~~
789 ~~individual, as provided by this subsection:~~
790 ~~1. Upon request of such health maintenance organization,~~
791 ~~the insurer or health maintenance organization that issued the~~
792 ~~certification provided by the individual shall promptly disclose~~
793 ~~to such requesting organization information on coverage of~~

180490

~~classes and categories of health benefits available under such insurer’s or health maintenance organization’s plan or coverage.~~

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

~~(c) The commission shall adopt rules to prevent an insurer’s or health maintenance organization’s failure to provide information under this subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health maintenance organization coverage.~~

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

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

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

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

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

180490

823 ~~(c) As an alternative to the method authorized by paragraph~~
824 ~~(a), a health maintenance organization may address adverse~~
825 ~~selection in a method approved by the office.~~
826 ~~(10)(a) Except as provided in paragraph (b), no period~~
827 ~~before July 1, 1996, shall be taken into account in determining~~
828 ~~creditable coverage.~~
829 ~~(b) The commission shall adopt rules that provide a process~~
830 ~~whereby individuals who need to establish creditable coverage~~
831 ~~for periods before July 1, 1996, and who would have such~~
832 ~~coverage credited but for paragraph (a), may be given credit for~~
833 ~~creditable coverage for such periods through the presentation of~~
834 ~~documents or other means.~~
835 ~~(11) Except as otherwise provided in this subsection, the~~
836 ~~requirements of paragraph (8)(b) shall apply to events that~~
837 ~~occur on or after July 1, 1996.~~
838 ~~(a) In no case is a certification required to be provided~~
839 ~~under paragraph (8)(b) prior to June 1, 1997.~~
840 ~~(b) In the case of an event that occurs on or after July 1,~~
841 ~~1996, and before October 1, 1996, a certification is not~~
842 ~~required to be provided under paragraph (8)(b), unless an~~
843 ~~individual, with respect to whom the certification is required~~
844 ~~to be made, requests such certification in writing.~~
845 ~~(12) In the case of an individual who seeks to establish~~
846 ~~creditable coverage for any period for which certification is~~
847 ~~not required because it relates to an event occurring before~~
848 ~~July 1, 1996:~~
849 ~~(a) The individual may present other creditable coverage in~~
850 ~~order to establish the period of creditable coverage.~~
851 ~~(b) A health maintenance organization is not subject to any~~

180490

852 ~~penalty or enforcement action with respect to the organization's~~
853 ~~crediting, or not crediting, such coverage if the organization~~
854 ~~has sought to comply in good faith with applicable provisions of~~
855 ~~this section.~~
856 ~~(13) For purposes of subsection (10), any plan amendment~~
857 ~~made pursuant to a collective bargaining agreement relating to~~
858 ~~the plan which amends the plan solely to conform to any~~
859 ~~requirement of this section may not be treated as a termination~~
860 ~~of such collective bargaining agreement.~~
861 Section 21. Subsections (1), (3), and (4) of section
862 641.31074, Florida Statutes, are amended to read:
863 641.31074 Guaranteed renewability of coverage.—
864 (1) Except as otherwise provided in this section, a health
865 maintenance organization that issues a ~~group~~ health insurance
866 contract must renew or continue in force such coverage at the
867 option of the contract holder.
868 (3)(a) A health maintenance organization may discontinue
869 offering a particular contract form ~~for group coverage offered~~
870 ~~in the small group market or large group market~~ only if:
871 1. The health maintenance organization provides notice to
872 each contract holder provided coverage of this form in such
873 market, and participants and beneficiaries covered under such
874 coverage, of such discontinuation at least 90 days prior to the
875 date of the nonrenewal of such coverage;
876 2. The health maintenance organization offers to each
877 contract holder provided coverage of this form in such market
878 the option to purchase all, or in the case of the large group
879 market, any other health insurance coverage currently being
880 offered by the health maintenance organization in such market;

180490

881 and
882 3. In exercising the option to discontinue coverage of this
883 form and in offering the option of coverage under subparagraph
884 2., the health maintenance organization acts uniformly without
885 regard to the claims experience of those contract holders or any
886 health-status-related factor that relates to any participants or
887 beneficiaries covered or new participants or beneficiaries who
888 may become eligible for such coverage.
889 (b)1. In any case in which a health maintenance
890 organization elects to discontinue offering all coverage in the
891 individual market, the small group market, ~~or~~ the large group
892 market, or any combination thereof ~~both,~~ in this state, coverage
893 may be discontinued by the insurer only if:
894 a. The health maintenance organization provides notice to
895 the office and to each contract holder, and participants and
896 beneficiaries covered under such coverage, of such
897 discontinuation at least 180 days prior to the date of the
898 nonrenewal of such coverage; and
899 b. All health insurance issued or delivered for issuance in
900 this state in such market is discontinued and coverage under
901 such health insurance coverage in such market is not renewed.
902 2. In the case of a discontinuation under subparagraph 1.
903 in a market, the health maintenance organization may not provide
904 for the issuance of any health maintenance organization contract
905 coverage in the market in this state during the 5-year period
906 beginning on the date of the discontinuation of the last
907 insurance contract not renewed.
908 (4) At the time of coverage renewal, a health maintenance
909 organization may modify the coverage for a product offered:

180490

910 (a) In the large group market; ~~or~~
911 (b) In the small group market if, for coverage that is
912 available in such market other than only through one or more
913 bona fide associations, as defined in s. 627.6571(5), such
914 modification is consistent with s. 627.6699 and effective on a
915 uniform basis among group health plans with that product; or
916 (c) In the individual market if the modification is
917 consistent with the laws of this state and effective on a
918 uniform basis among all individuals with that policy form.
919
920 ================= T I T L E A M E N D M E N T ================
921 And the title is amended as follows:
922 Delete lines 29 - 55
923 and insert:
924 types of benefits or coverages; amending s. 627.6561,
925 F.S.; conforming a cross-reference; revising
926 conditions under which an insurer may impose a
927 preexisting condition exclusion; deleting the
928 definition of the term "creditable coverage"; removing
929 certain requirements relating to creditable coverage
930 to conform to changes made by the act; amending s.
931 627.6562, F.S.; redefining the term "creditable
932 coverage"; providing exceptions and applicability;
933 amending s. 627.65626, F.S.; conforming a cross-
934 reference; amending s. 627.6699, F.S.; redefining
935 terms; deleting a provision that requires a certain
936 health benefit plan to comply with specified
937 preexisting condition provisions; amending s.
938 627.6741, F.S.; conforming cross-references;

180490

939 conforming a provision to changes made by the act;
940 amending s. 641.31, F.S.; deleting a provision
941 specifying that a law restricting or limiting
942 deductibles, coinsurance, copayments, or annual or
943 lifetime maximum payments may not apply to a certain
944 health maintenance organization contract; conforming a
945 cross-reference; amending s. 641.31071, F.S.;
946 conforming a cross-reference; deleting the definition
947 of the term “creditable coverage”; removing certain
948 requirements relating to creditable coverage to
949 conform to changes made by the act; amending s.
950 641.31074; requiring a health maintenance organization
951 that issues a health insurance contract, rather than a
952 group health insurance contract, to renew or continue
953 in force such coverage at the contract holder’s
954 option; revising conditions under which a health
955 maintenance organization may discontinue offering a
956 particular contract form; adding to the conditions
957 under which a health maintenance organization may, at
958 the time of coverage renewal, modify coverage for a
959 product offered; amending s.