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Proposed Committee Substitute by the Committee on Appropriations  
(Appropriations Subcommittee on Health and Human Services)

A bill to be entitled

An act relating to health plan regulatory  
administration; amending s. 408.909, F.S.; redefining  
the term "health care coverage" or "health flex plan  
coverage"; amending s. 409.817, F.S.; deleting a  
provision authorizing group insurance plans to impose  
a certain preexisting condition exclusion; amending s.  
624.123, F.S.; conforming a cross-reference; amending  
s. 627.402, F.S.; redefining the term  
"nongrandfathered health plan"; amending s. 627.411,  
F.S.; deleting a provision relating to a minimum loss  
ratio standard for specified health insurance  
coverage; deleting provisions specifying certain  
incurred claims; amending s. 627.6011, F.S.,  
conforming a cross-reference; amending s. 627.602,  
F.S.; conforming a cross-reference; amending s.  
627.642, F.S.; revising the policies to which certain  
outline of coverage requirements apply; amending s.  
627.6425, F.S.; redefining the term "individual health  
insurance"; revising applicability; amending s.  
627.6487, F.S.; redefining terms; repealing s.  
627.64871, F.S., relating to certification of  
coverage; amending s. 627.6512, F.S.; revising a  
provision specifying that certain sections of the  
Florida Insurance Code do not apply to a group health  
insurance policy as that policy relates to specified  
benefits, under certain circumstances; amending s.



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28 627.6513, F.S.; excluding applicability as to certain  
29 types of benefits or coverages; amending s. 627.6561,  
30 F.S.; conforming a cross-reference; revising  
31 conditions under which an insurer may impose a  
32 preexisting condition exclusion; deleting the  
33 definition of the term "creditable coverage"; removing  
34 certain requirements relating to creditable coverage  
35 to conform to changes made by the act; amending s.  
36 627.6562, F.S.; redefining the term "creditable  
37 coverage"; providing exceptions and applicability;  
38 amending s. 627.65626, F.S.; conforming a cross-  
39 reference; amending s. 627.6699, F.S.; redefining  
40 terms; deleting a provision that requires a certain  
41 health benefit plan to comply with specified  
42 preexisting condition provisions; amending s.  
43 627.6741, F.S.; conforming cross-references;  
44 conforming a provision to changes made by the act;  
45 amending s. 641.31, F.S.; deleting a provision  
46 specifying that a law restricting or limiting  
47 deductibles, coinsurance, copayments, or annual or  
48 lifetime maximum payments may not apply to a certain  
49 health maintenance organization contract; conforming a  
50 cross-reference; amending s. 641.31071, F.S.;  
51 conforming a cross-reference; deleting the definition  
52 of the term "creditable coverage"; removing certain  
53 requirements relating to creditable coverage to  
54 conform to changes made by the act; amending s.  
55 641.31074; requiring a health maintenance organization  
56 that issues a health insurance contract, rather than a



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57 group health insurance contract, to renew or continue  
58 in force such coverage at the contract holder's  
59 option; revising conditions under which a health  
60 maintenance organization may discontinue offering a  
61 particular contract form; adding to the conditions  
62 under which a health maintenance organization may, at  
63 the time of coverage renewal, modify coverage for a  
64 product offered; amending s. 641.312, F.S.; conforming  
65 a cross-reference; providing an effective date.

66

67 Be It Enacted by the Legislature of the State of Florida:

68

69 Section 1. Paragraph (d) of subsection (2) of section  
70 408.909, Florida Statutes, is amended to read:

71 408.909 Health flex plans.—

72 (2) DEFINITIONS.—As used in this section, the term:

73 (d) "Health care coverage" or "health flex plan coverage"  
74 means health care services that are covered as benefits under an  
75 approved health flex plan or that are otherwise provided, either  
76 directly or through arrangements with other persons, via a  
77 health flex plan on a prepaid per capita basis or on a prepaid  
78 aggregate fixed-sum basis. The terms may also include one or  
79 more of the excepted benefits under s. 627.6513(1)-(13) ~~s.~~  
80 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~  
81 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~  
82 ~~as independent, noncoordinated benefits.~~

83 Section 2. Section 409.817, Florida Statutes, is amended to  
84 read:

85 409.817 Approval of health benefits coverage; financial



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86 assistance.—In order for health insurance coverage to qualify  
87 for premium assistance payments for an eligible child under ss.  
88 409.810-409.821, the health benefits coverage must:

89 (1) Be certified by the Office of Insurance Regulation of  
90 the Financial Services Commission under s. 409.818 as meeting,  
91 exceeding, or being actuarially equivalent to the benchmark  
92 benefit plan;

93 (2) Be guarantee issued;

94 (3) Be community rated;

95 (4) Not impose any preexisting condition exclusion for  
96 covered benefits; ~~however, group health insurance plans may~~  
97 ~~permit the imposition of a preexisting condition exclusion, but~~  
98 ~~only insofar as it is permitted under s. 627.6561;~~

99 (5) Comply with the applicable limitations on premiums and  
100 cost sharing in s. 409.816;

101 (6) Comply with the quality assurance and access standards  
102 developed under s. 409.820; and

103 (7) Establish periodic open enrollment periods, which may  
104 not occur more frequently than quarterly.

105 Section 3. Paragraph (b) of subsection (1) of section  
106 624.123, Florida Statutes, is amended to read:

107 624.123 Certain international health insurance policies;  
108 exemption from code.—

109 (1) International health insurance policies and  
110 applications may be solicited and sold in this state at any  
111 international airport to a resident of a foreign country. Such  
112 international health insurance policies shall be solicited and  
113 sold only by a licensed health insurance agent and underwritten  
114 only by an admitted insurer. For purposes of this subsection:



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115 (b) "International health insurance policy" means health  
116 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2. ~~s.~~  
117 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering  
118 only a resident of a foreign country on an annual basis.

119 Section 4. Subsection (2) of section 627.402, Florida  
120 Statutes, is amended to read:

121 627.402 Definitions.—As used in this part, the term:

122 (2) "Nongrandfathered health plan" is a health insurance  
123 policy or health maintenance organization contract that is not a  
124 grandfathered health plan and does not provide the benefits or  
125 coverages specified under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-~~  
126 ~~(e).~~

127 Section 5. Subsection (3) of section 627.411, Florida  
128 Statutes, is amended to read:

129 627.411 Grounds for disapproval.—

130 ~~(3)(a) For health insurance coverage as described in s.~~  
131 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~  
132 ~~claims to earned premium for the form shall be 65 percent.~~

133 ~~(b) Incurred claims are claims occurring within a fixed~~  
134 ~~period, whether or not paid during the same period, under the~~  
135 ~~terms of the policy period.~~

136 ~~1. Claims include scheduled benefit payments or services~~  
137 ~~provided by a provider or through a provider network for dental,~~  
138 ~~vision, disability, and similar health benefits.~~

139 ~~2. Claims do not include state assessments, taxes, company~~  
140 ~~expenses, or any expense incurred by the company for the cost of~~  
141 ~~adjusting and settling a claim, including the review,~~  
142 ~~qualification, oversight, management, or monitoring of a claim~~  
143 ~~or incentives or compensation to providers for other than the~~



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144 ~~provisions of health care services.~~

145 ~~3. A company may at its discretion include costs that are~~  
146 ~~demonstrated to reduce claims, such as fraud intervention~~  
147 ~~programs or case management costs, which are identified in each~~  
148 ~~filing, are demonstrated to reduce claims costs, and do not~~  
149 ~~result in increasing the experience period loss ratio by more~~  
150 ~~than 5 percent.~~

151 ~~4. For scheduled claim payments, such as disability income~~  
152 ~~or long-term care, the incurred claims shall be the present~~  
153 ~~value of the benefit payments discounted for continuance and~~  
154 ~~interest.~~

155 Section 6. Section 627.6011, Florida Statutes, is amended  
156 to read:

157 627.6011 Mandated coverages.—Mandatory health benefits  
158 regulated under this chapter are not intended to apply to the  
159 types of health benefit plans listed in s. 627.6513(1)-(14) ~~s.~~  
160 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically  
161 designated otherwise. For purposes of this section, the term  
162 “mandatory health benefits” means those benefits set forth in  
163 ss. 627.6401-627.64193, and any other mandatory treatment or  
164 health coverages or benefits enacted on or after July 1, 2012.

165 Section 7. Paragraph (h) of subsection (1) of section  
166 627.602, Florida Statutes, is amended to read:

167 627.602 Scope, format of policy.—

168 (1) Each health insurance policy delivered or issued for  
169 delivery to any person in this state must comply with all  
170 applicable provisions of this code and all of the following  
171 requirements:

172 (h) Section 641.312 and the provisions of the Employee



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173 Retirement Income Security Act of 1974, as implemented by 29  
174 C.F.R. s. 2560.503-1, relating to internal grievances. This  
175 paragraph does not apply to a health insurance policy that is  
176 subject to the Subscriber Assistance Program under s. 408.7056  
177 or to the types of benefits or coverages provided under s.  
178 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(c)~~ issued in any market.

179 Section 8. Subsection (1) of section 627.642, Florida  
180 Statutes, is amended to read:

181 627.642 Outline of coverage.—

182 (1) A policy offering benefits defined in s. 627.6513(1)-  
183 (14) or a large group ~~No individual or family accident and~~  
184 ~~health insurance~~ policy may not shall be delivered, or issued  
185 for delivery, in this state unless:

186 (a) It is accompanied by an appropriate outline of  
187 coverage; or

188 (b) An appropriate outline of coverage is completed and  
189 delivered to the applicant at the time application is made, and  
190 an acknowledgment of receipt or certificate of delivery of such  
191 outline is provided to the insurer with the application.

192  
193 In the case of a direct response, such as a written application  
194 to the insurance company from an applicant, the outline of  
195 coverage shall accompany the policy when issued.

196 Section 9. Subsections (1), (6), and (7) of section  
197 627.6425, Florida Statutes, are amended, to read:

198 627.6425 Renewability of individual coverage.—

199 (1) Except as otherwise provided in this section, an  
200 insurer that provides individual health insurance coverage to an  
201 individual shall renew or continue in force such coverage at the



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202 option of the individual. For the purpose of this section, the  
203 term "individual health insurance" means health insurance  
204 coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~,  
205 offered to an individual in this state, including certificates  
206 of coverage offered to individuals in this state as part of a  
207 group policy issued to an association outside this state, but  
208 the term does not include short-term limited duration insurance  
209 or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~  
210 ~~(6) or subsection (7).~~

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

214 ~~(7) The requirements of this section do not apply to any~~  
215 ~~health insurance coverage in relation to its provision of~~  
216 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~  
217 ~~if the benefits are provided under a separate policy,~~  
218 ~~certificate, or contract of insurance.~~

219 Section 10. Paragraph (b) of subsection (2) and subsection  
220 (3) of section 627.6487, Florida Statutes, are amended to read:

221 627.6487 Guaranteed availability of individual health  
222 insurance coverage to eligible individuals.-

223 (2) For the purposes of this section:

224 (b) "Individual health insurance" means health insurance,  
225 as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered  
226 to an individual, including certificates of coverage offered to  
227 individuals in this state as part of a group policy issued to an  
228 association outside this state, but the term does not include  
229 short-term limited duration insurance or excepted benefits  
230 specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the~~





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231 ~~benefits are provided under a separate policy, certificate, or~~  
232 ~~contract, the term does not include excepted benefits specified~~  
233 ~~in s. 627.6561(5)(c), (d), or (e).~~

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

236 (a)1. For whom, as of the date on which the individual  
237 seeks coverage under this section, the aggregate of the periods  
238 of creditable coverage, as defined in s. 627.6562(3) ~~s.~~  
239 ~~627.6561(5) and (6)~~, is 18 or more months; and

240 2.a. Whose most recent prior creditable coverage was under  
241 a group health plan, governmental plan, or church plan, or  
242 health insurance coverage offered in connection with any such  
243 plan; or

244 b. Whose most recent prior creditable coverage was under an  
245 individual plan issued in this state by a health insurer or  
246 health maintenance organization, which coverage is terminated  
247 due to the insurer or health maintenance organization becoming  
248 insolvent or discontinuing the offering of all individual  
249 coverage in the State of Florida, or due to the insured no  
250 longer living in the service area in the State of Florida of the  
251 insurer or health maintenance organization that provides  
252 coverage through a network plan in the State of Florida;

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

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

256 2. A conversion policy or contract issued by an authorized  
257 insurer or health maintenance organization under s. 627.6675 or  
258 s. 641.3921, respectively, offered to an individual who is no  
259 longer eligible for coverage under either an insured or self-



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260 insured employer plan;

261 3. Part A or part B of Title XVIII of the Social Security  
262 Act; or

263 4. A state plan under Title XIX of such act, or any  
264 successor program, and does not have other health insurance  
265 coverage;

266 (c) With respect to whom the most recent coverage within  
267 the coverage period described in paragraph (a) was not  
268 terminated based on a factor described in s. 627.6571(2) (a) or  
269 (b), relating to nonpayment of premiums or fraud, unless such  
270 nonpayment of premiums or fraud was due to acts of an employer  
271 or person other than the individual;

272 (d) Who, having been offered the option of continuation  
273 coverage under a COBRA continuation provision or under s.  
274 627.6692, elected such coverage; and

275 (e) Who, if the individual elected such continuation  
276 provision, has exhausted such continuation coverage under such  
277 provision or program.

278 Section 11. Section 627.64871, Florida Statutes, is  
279 repealed.

280 Section 12. Section 627.6512, Florida Statutes, is amended  
281 to read:

282 627.6512 Exemption of certain group health insurance  
283 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571  
284 do not apply to:

285 ~~(1)~~ any group insurance policy in relation to its provision  
286 of ~~excepted~~ benefits described in s. 627.6513(1)-(14)  
287 ~~627.6561(5) (b).~~

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



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289 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~  
290 ~~if the benefits:~~

291 ~~(a) Are provided under a separate policy, certificate, or~~  
292 ~~contract of insurance; or~~

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

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

297 ~~(a) The benefits are provided under a separate policy,~~  
298 ~~certificate, or contract of insurance;~~

299 ~~(b) There is no coordination between the provision of such~~  
300 ~~benefits and any exclusion of benefits under any group policy~~  
301 ~~maintained by the same policyholder; and~~

302 ~~(c) Such benefits are paid with respect to an event without~~  
303 ~~regard to whether benefits are provided with respect to such an~~  
304 ~~event under any group health policy maintained by the same~~  
305 ~~policyholder.~~

306 ~~(4) Any group health policy in relation to its provision of~~  
307 ~~excepted benefits described in s. 627.6561(5)(c), if the~~  
308 ~~benefits are provided under a separate policy, certificate, or~~  
309 ~~contract of insurance.~~

310 Section 13. Section 627.6513, Florida Statutes, is amended  
311 to read:

312 627.6513 Scope.—Section 641.312 and the provisions of the  
313 Employee Retirement Income Security Act of 1974, as implemented  
314 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,  
315 apply to all group health insurance policies issued under this  
316 part. This section does not apply to a group health insurance  
317 policy that is subject to the Subscriber Assistance Program in



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318 s. 408.7056 or to: ~~the types of benefits or coverages provided~~  
319 ~~under s. 627.6561(5)(b)-(c) issued in any market.~~

320 (1) Coverage only for accident insurance, or disability  
321 income insurance, or any combination thereof.

322 (2) Coverage issued as a supplement to liability insurance.

323 (3) Liability insurance, including general liability  
324 insurance and automobile liability insurance.

325 (4) Workers' compensation or similar insurance.

326 (5) Automobile medical payment insurance.

327 (6) Credit-only insurance.

328 (7) Coverage for onsite medical clinics, including prepaid  
329 health clinics under part II of chapter 641.

330 (8) Other similar insurance coverage, specified in rules  
331 adopted by the commission, under which benefits for medical care  
332 are secondary or incidental to other insurance benefits. To the  
333 extent possible, such rules must be consistent with regulations  
334 adopted by the United States Department of Health and Human  
335 Services.

336 (9) Limited scope dental or vision benefits, if offered  
337 separately.

338 (10) Benefits for long-term care, nursing home care, home  
339 health care, or community-based care, or any combination  
340 thereof, if offered separately.

341 (11) Other similar, limited benefits, if offered  
342 separately, as specified in rules adopted by the commission.

343 (12) Coverage only for a specified disease or illness, if  
344 offered as independent, noncoordinated benefits.

345 (13) Hospital indemnity or other fixed indemnity insurance,  
346 if offered as independent, noncoordinated benefits.



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347       (14) Benefits provided through a Medicare supplemental  
348 health insurance policy, as defined under s. 1882(g)(1) of the  
349 Social Security Act, coverage supplemental to the coverage  
350 provided under 10 U.S.C. chapter 55, and similar supplemental  
351 coverage provided to coverage under a group health plan, which  
352 are offered as a separate insurance policy and as independent,  
353 noncoordinated benefits.

354       Section 14. Section 627.6561, Florida Statutes, is amended  
355 to read:

356       627.6561 Preexisting conditions.—

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

358       (a) "Enrollment date" means, with respect to an individual  
359 covered under a group health policy, the date of enrollment of  
360 the individual in the plan or coverage or, if earlier, the first  
361 day of the waiting period of such enrollment.

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

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

367       2. A special enrollment period, as provided under s.  
368 627.65615.

369       (c) "Waiting period" means, with respect to a group health  
370 policy and an individual who is a potential participant or  
371 beneficiary of the policy, the period that must pass with  
372 respect to the individual before the individual is eligible to  
373 be covered for benefits under the terms of the policy.

374       (2) Subject to the exceptions specified in subsection (4),  
375 an insurer that offers group health insurance coverage may, with



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376 respect to a participant or beneficiary, impose a preexisting  
377 condition exclusion only if:

378 (a) Such exclusion relates to a physical or mental  
379 condition, regardless of the cause of the condition, for which  
380 medical advice, diagnosis, care, or treatment was recommended or  
381 received within the 6-month period ending on the enrollment  
382 date;

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

386 (c) The period of any such preexisting condition exclusion  
387 is reduced by the aggregate of the periods of creditable  
388 coverage, as defined in s. 627.6562(3) subsection (5),  
389 applicable to the participant or beneficiary as of the  
390 enrollment date.

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

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

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

400 2. A child who is adopted or placed for adoption before  
401 attaining 18 years of age and who, as of the last day of the 30-  
402 day period beginning on the date of the adoption or placement  
403 for adoption, is covered under creditable coverage. This  
404 provision does not apply to coverage before the date of such



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405 adoption or placement for adoption.

406 3. Pregnancy.

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

410 ~~(5) (a) The term, "creditable coverage," means, with respect~~  
411 ~~to an individual, coverage of the individual under any of the~~  
412 ~~following:~~

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

415 ~~2. Health insurance coverage consisting of medical care,~~  
416 ~~provided directly, through insurance or reimbursement, or~~  
417 ~~otherwise and including terms and services paid for as medical~~  
418 ~~care, under any hospital or medical service policy or~~  
419 ~~certificate, hospital or medical service plan contract, or~~  
420 ~~health maintenance contract offered by a health insurance~~  
421 ~~issuer.~~

422 ~~3. Part A or part B of Title XVIII of the Social Security~~  
423 ~~Act.~~

424 ~~4. Title XIX of the Social Security Act, other than~~  
425 ~~coverage consisting solely of benefits under s. 1928.~~

426 ~~5. Chapter 55 of Title 10, United States Code.~~

427 ~~6. A medical care program of the Indian Health Service or~~  
428 ~~of a tribal organization.~~

429 ~~7. The Florida Comprehensive Health Association or another~~  
430 ~~state health benefit risk pool.~~

431 ~~8. A health plan offered under chapter 89 of Title 5,~~  
432 ~~United States Code.~~

433 ~~9. A public health plan as defined by rules adopted by the~~



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434 ~~commission. To the greatest extent possible, such rules must be~~  
435 ~~consistent with regulations adopted by the United States~~  
436 ~~Department of Health and Human Services.~~

437 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~  
438 ~~Act (22 U.S.C. s. 2504(e)).~~

439 ~~(b) Creditable coverage does not include coverage that~~  
440 ~~consists solely of one or more or any combination thereof of the~~  
441 ~~following excepted benefits:~~

442 ~~1. Coverage only for accident, or disability income~~  
443 ~~insurance, or any combination thereof.~~

444 ~~2. Coverage issued as a supplement to liability insurance.~~

445 ~~3. Liability insurance, including general liability~~  
446 ~~insurance and automobile liability insurance.~~

447 ~~4. Workers' compensation or similar insurance.~~

448 ~~5. Automobile medical payment insurance.~~

449 ~~6. Credit only insurance.~~

450 ~~7. Coverage for onsite medical clinics, including prepaid~~  
451 ~~health clinics under part II of chapter 641.~~

452 ~~8. Other similar insurance coverage, specified in rules~~  
453 ~~adopted by the commission, under which benefits for medical care~~  
454 ~~are secondary or incidental to other insurance benefits. To the~~  
455 ~~extent possible, such rules must be consistent with regulations~~  
456 ~~adopted by the United States Department of Health and Human~~  
457 ~~Services.~~

458 ~~(c) The following benefits are not subject to the~~  
459 ~~creditable coverage requirements, if offered separately:~~

460 ~~1. Limited scope dental or vision benefits.~~

461 ~~2. Benefits for long term care, nursing home care, home~~  
462 ~~health care, community-based care, or any combination thereof.~~





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463 ~~3. Such other similar, limited benefits as are specified in~~  
464 ~~rules adopted by the commission.~~

465 ~~(d) The following benefits are not subject to creditable~~  
466 ~~coverage requirements if offered as independent, noncoordinated~~  
467 ~~benefits:~~

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

469 ~~2. Hospital indemnity or other fixed indemnity insurance.~~

470 ~~(e) Benefits provided through a Medicare supplemental~~  
471 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~  
472 ~~Security Act, coverage supplemental to the coverage provided~~  
473 ~~under chapter 55 of Title 10, United States Code, and similar~~  
474 ~~supplemental coverage provided to coverage under a group health~~  
475 ~~plan are not considered creditable coverage if offered as a~~  
476 ~~separate insurance policy.~~

477 ~~(6)(a) A period of creditable coverage may not be counted,~~  
478 ~~with respect to enrollment of an individual under a group health~~  
479 ~~plan, if, after such period and before the enrollment date,~~  
480 ~~there was a 63-day period during all of which the individual was~~  
481 ~~not covered under any creditable coverage.~~

482 ~~(b) Any period during which an individual is in a waiting~~  
483 ~~period for any coverage under a group health plan or for group~~  
484 ~~health insurance coverage may not be taken into account in~~  
485 ~~determining the 63-day period under paragraph (a) or paragraph~~  
486 ~~(4)(b).~~

487 ~~(7)(a) Except as otherwise provided under paragraph (b), an~~  
488 ~~insurer shall count a period of creditable coverage without~~  
489 ~~regard to the specific benefits covered under the period.~~

490 ~~(b) An insurer may elect to count, as creditable coverage,~~  
491 ~~coverage of benefits within each of several classes or~~



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492 ~~categories of benefits specified in rules adopted by the~~  
493 ~~commission rather than as provided under paragraph (a). To the~~  
494 ~~extent possible, such rules must be consistent with regulations~~  
495 ~~adopted by the United States Department of Health and Human~~  
496 ~~Services. Such election shall be made on a uniform basis for all~~  
497 ~~participants and beneficiaries. Under such election, an insurer~~  
498 ~~shall count a period of creditable coverage with respect to any~~  
499 ~~class or category of benefits if any level of benefits is~~  
500 ~~covered within such class or category.~~

501 ~~(c) In the case of an election with respect to an insurer~~  
502 ~~under paragraph (b), the insurer shall:~~

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

507 ~~2. Include in such statements a description of the effect~~  
508 ~~of this election.~~

509 ~~(8)(a) Periods of creditable coverage with respect to an~~  
510 ~~individual shall be established through presentation of~~  
511 ~~certifications described in this subsection or in such other~~  
512 ~~manner as is specified in rules adopted by the commission. To~~  
513 ~~the extent possible, such rules must be consistent with~~  
514 ~~regulations adopted by the United States Department of Health~~  
515 ~~and Human Services.~~

516 ~~(b) An insurer that offers group health insurance coverage~~  
517 ~~shall provide the certification described in paragraph (a):~~

518 ~~1. At the time an individual ceases to be covered under the~~  
519 ~~plan or otherwise becomes covered under a COBRA continuation~~  
520 ~~provision or continuation pursuant to s. 627.6692.~~



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521 ~~2. In the case of an individual becoming covered under a~~  
522 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~  
523 ~~time the individual ceases to be covered under such a provision.~~

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

527  
528 ~~The certification under subparagraph 1. may be provided, to the~~  
529 ~~extent practicable, at a time consistent with notices required~~  
530 ~~under any applicable COBRA continuation provision or~~  
531 ~~continuation pursuant to s. 627.6692.~~

532 ~~(c) The certification described in this section is a~~  
533 ~~written certification that must include:~~

534 ~~1. The period of creditable coverage of the individual~~  
535 ~~under the policy and the coverage, if any, under such COBRA~~  
536 ~~continuation provision or continuation pursuant to s. 627.6692;~~  
537 ~~and~~

538 ~~2. The waiting period, if any, imposed with respect to the~~  
539 ~~individual for any coverage under such policy.~~

540 ~~(d) In the case of an election described in subsection (7)~~  
541 ~~by an insurer, if the insurer enrolls an individual for coverage~~  
542 ~~under the plan and the individual provides a certification of~~  
543 ~~coverage of the individual, as provided in this subsection:~~

544 ~~1. Upon request of such insurer, the insurer that issued~~  
545 ~~the certification provided by the individual shall promptly~~  
546 ~~disclose to such requesting plan or insurer information on~~  
547 ~~coverage of classes and categories of health benefits available~~  
548 ~~under such insurer's plan or coverage.~~

549 ~~2. Such insurer may charge the requesting insurer for the~~



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550 ~~reasonable cost of disclosing such information.~~

551 ~~(c) The commission shall adopt rules to prevent an~~  
552 ~~insurer's failure to provide information under this subsection~~  
553 ~~with respect to previous coverage of an individual from~~  
554 ~~adversely affecting any subsequent coverage of the individual~~  
555 ~~under another group health plan or health insurance coverage. To~~  
556 ~~the greatest extent possible, such rules must be consistent with~~  
557 ~~regulations adopted by the United States Department of Health~~  
558 ~~and Human Services.~~

559 ~~(9) (a) Except as provided in paragraph (b), no period~~  
560 ~~before July 1, 1996, shall be taken into account in determining~~  
561 ~~creditable coverage.~~

562 ~~(b) The commission shall adopt rules that provide a process~~  
563 ~~whereby individuals who need to establish creditable coverage~~  
564 ~~for periods before July 1, 1996, and who would have such~~  
565 ~~coverage credited but for paragraph (a), may be given credit for~~  
566 ~~creditable coverage for such periods through the presentation of~~  
567 ~~documents or other means. To the greatest extent possible, such~~  
568 ~~rules must be consistent with regulations adopted by the United~~  
569 ~~States Department of Health and Human Services.~~

570 ~~(10) Except as otherwise provided in this subsection,~~  
571 ~~paragraph (8) (b) applies to events that occur on or after July~~  
572 ~~1, 1996.~~

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

575 ~~(b) In the case of an event that occurred on or after July~~  
576 ~~1, 1996, and before October 1, 1996, a certification is not~~  
577 ~~required to be provided under paragraph (8) (b), unless an~~  
578 ~~individual, with respect to whom the certification is required~~



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579 ~~to be made, requests such certification in writing.~~

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

584 ~~(a) The individual may present other creditable coverage in~~  
585 ~~order to establish the period of creditable coverage.~~

586 ~~(b) An insurer is not subject to any penalty or enforcement~~  
587 ~~action with respect to the insurer's crediting, or not~~  
588 ~~crediting, such coverage if the insurer has sought to comply in~~  
589 ~~good faith with applicable provisions of this section.~~

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

595 ~~(13) This section does not apply to any health insurance~~  
596 ~~coverage in relation to its provision of excepted benefits~~  
597 ~~described in paragraph (5) (b).~~

598 ~~(14) This section does not apply to any health insurance~~  
599 ~~coverage in relation to its provision of excepted benefits~~  
600 ~~described in paragraphs (5) (c), (d), or (e), if the benefits are~~  
601 ~~provided under a separate policy, certificate, or contract of~~  
602 ~~insurance.~~

603 ~~(15) This section applies to health insurance coverage~~  
604 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~  
605 ~~1997.~~

606 Section 15. Subsection (3) of section 627.6562, Florida  
607 Statutes, is amended to read:



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608 627.6562 Dependent coverage.—

609 (3) If, pursuant to subsection (2), a child is provided  
610 coverage under the parent's policy after the end of the calendar  
611 year in which the child reaches age 25 and coverage for the  
612 child is subsequently terminated, the child is not eligible to  
613 be covered under the parent's policy unless the child was  
614 continuously covered by other creditable coverage without a gap  
615 in coverage of more than 63 days.

616 (a) For the purposes of this subsection, the term  
617 "creditable coverage" means, with respect to an individual,  
618 coverage of the individual under any of the following: has the  
619 same meaning as provided in s. 627.6561(5).

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

622 2. Health insurance coverage consisting of medical care  
623 provided directly through insurance or reimbursement or  
624 otherwise, and including terms and services paid for as medical  
625 care, under any hospital or medical service policy or  
626 certificate, hospital or medical service plan contract, or  
627 health maintenance contract offered by a health insurance  
628 issuer.

629 3. Part A or part B of Title XVIII of the Social Security  
630 Act.

631 4. Title XIX of the Social Security Act, other than  
632 coverage consisting solely of benefits under s. 1928.

633 5. Title 10 U.S.C. chapter 55.

634 6. A medical care program of the Indian Health Service or  
635 of a tribal organization.

636 7. The Florida Comprehensive Health Association or another



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637 state health benefit risk pool.

638 8. A health plan offered under 5 U.S.C. chapter 89.

639 9. A public health plan as defined by rules adopted by the  
640 commission. To the greatest extent possible, such rules must be  
641 consistent with regulations adopted by the United States  
642 Department of Health and Human Services.

643 10. A health benefit plan under s. 5(e) of the Peace Corps  
644 Act, 22 U.S.C. s. 2504(e).

645 (b) Creditable coverage does not include coverage that  
646 consists of one or more, or any combination thereof, of the  
647 following excepted benefits:

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

650 2. Coverage issued as a supplement to liability insurance.

651 3. Liability insurance, including general liability  
652 insurance and automobile liability insurance.

653 4. Workers' compensation or similar insurance.

654 5. Automobile medical payment insurance.

655 6. Credit-only insurance.

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

658 8. Other similar insurance coverage specified in rules  
659 adopted by the commission under which benefits for medical care  
660 are secondary or incidental to other insurance benefits. To the  
661 extent possible, such rules must be consistent with regulations  
662 adopted by the United States Department of Health and Human  
663 Services.

664 (c) The following benefits are not subject to the  
665 creditable coverage requirements, if offered separately:



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- 666       1. Limited scope dental or vision benefits.  
667       2. Benefits for long-term care, nursing home care, home  
668 health care, community-based care, or any combination thereof.  
669       3. Other similar, limited benefits specified in rules  
670 adopted by the commission.

671       (d) The following benefits are not subject to creditable  
672 coverage requirements if offered as independent, noncoordinated  
673 benefits:

- 674       1. Coverage only for a specified disease or illness.  
675       2. Hospital indemnity or other fixed indemnity insurance.

676       (e) Benefits provided through a Medicare supplemental  
677 health insurance policy, as defined under s. 1882(g)(1) of the  
678 Social Security Act, coverage supplemental to the coverage  
679 provided under 10 U.S.C. chapter 55, and similar supplemental  
680 coverage provided to coverage under a group health plan are not  
681 considered creditable coverage if offered as a separate  
682 insurance policy.

683       Section 16. Subsection (1) of section 627.65626, Florida  
684 Statutes, is amended to read:

685       627.65626 Insurance rebates for healthy lifestyles.—

686       (1) Any rate, rating schedule, or rating manual for a  
687 health insurance policy that provides creditable coverage as  
688 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office  
689 shall provide for an appropriate rebate of premiums paid in the  
690 last policy year, contract year, or calendar year when the  
691 majority of members of a health plan have enrolled and  
692 maintained participation in any health wellness, maintenance, or  
693 improvement program offered by the group policyholder and health  
694 plan. The rebate may be based upon premiums paid in the last





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695 calendar year or policy year. The group must provide evidence of  
696 demonstrative maintenance or improvement of the enrollees'  
697 health status as determined by assessments of agreed-upon health  
698 status indicators between the policyholder and the health  
699 insurer, including, but not limited to, reduction in weight,  
700 body mass index, and smoking cessation. The group or health  
701 insurer may contract with a third-party administrator to  
702 assemble and report the health status required in this  
703 subsection between the policyholder and the health insurer. Any  
704 rebate provided by the health insurer is presumed to be  
705 appropriate unless credible data demonstrates otherwise, or  
706 unless the rebate program requires the insured to incur costs to  
707 qualify for the rebate which equal or exceed the value of the  
708 rebate, but the rebate may not exceed 10 percent of paid  
709 premiums.

710 Section 17. Paragraphs (e) and (1) of subsection (3) and  
711 paragraph (d) of subsection (5) of section 627.6699, Florida  
712 Statutes, are amended to read:

713 627.6699 Employee Health Care Access Act.—

714 (3) DEFINITIONS.—As used in this section, the term:

715 (e) "Creditable coverage" has the same meaning as provided  
716 ~~ascribed~~ in s. 627.6562(3) ~~627.6561~~.

717 (1) "Late enrollee" means an eligible employee or dependent  
718 who, with respect to coverage under a group health policy, is a  
719 participant or beneficiary who enrolls under the policy other  
720 than during:

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

723 2. A special enrollment period, as provided under s.



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724 ~~627.65615 as defined under s. 627.6561(1)(b).~~

725 (5) AVAILABILITY OF COVERAGE.—

726 (d) A health benefit plan covering small employers, issued  
727 or renewed on or after January 1, 1994, must comply with the  
728 following conditions:

729 1. All health benefit plans must be offered and issued on a  
730 guaranteed-issue basis. Additional or increased benefits may  
731 only be offered by riders.

732 ~~2. Paragraph (c) applies to health benefit plans issued to  
733 a small employer who has two or more eligible employees and to  
734 health benefit plans that are issued to a small employer who has  
735 fewer than two eligible employees and that cover an employee who  
736 has had creditable coverage continually to a date not more than  
737 63 days before the effective date of the new coverage.~~

738 ~~2.3.~~ For health benefit plans that are issued to a small  
739 employer who has fewer than two employees and that cover an  
740 employee who has not been continually covered by creditable  
741 coverage within 63 days before the effective date of the new  
742 coverage, preexisting condition provisions must not exclude  
743 coverage for a period beyond 24 months following the employee's  
744 effective date of coverage and may relate only to:

745 a. Conditions that, during the 24-month period immediately  
746 preceding the effective date of coverage, had manifested  
747 themselves in such a manner as would cause an ordinarily prudent  
748 person to seek medical advice, diagnosis, care, or treatment or  
749 for which medical advice, diagnosis, care, or treatment was  
750 recommended or received; or

751 b. A pregnancy existing on the effective date of coverage.

752 Section 18. Subsection (1) and paragraph (c) of subsection



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753 (2) of section 627.6741, Florida Statutes, are amended to read:  
754 627.6741 Issuance, cancellation, nonrenewal, and  
755 replacement.—

756 (1)(a) An insurer issuing Medicare supplement policies in  
757 this state shall offer the opportunity of enrolling in a  
758 Medicare supplement policy, without conditioning the issuance or  
759 effectiveness of the policy on, and without discriminating in  
760 the price of the policy based on, the medical or health status  
761 or receipt of health care by the individual:

762 1. To any individual who is 65 years of age or older, or  
763 under 65 years of age and eligible for Medicare by reason of  
764 disability or end-stage renal disease, and who resides in this  
765 state, upon the request of the individual during the 6-month  
766 period beginning with the first month in which the individual  
767 has attained 65 years of age and is enrolled in Medicare Part B,  
768 or is eligible for Medicare by reason of a disability or end-  
769 stage renal disease, and is enrolled in Medicare Part B; or

770 2. To any individual who is 65 years of age or older, or  
771 under 65 years of age and eligible for Medicare by reason of a  
772 disability or end-stage renal disease, who is enrolled in  
773 Medicare Part B, and who resides in this state, upon the request  
774 of the individual during the 2-month period following  
775 termination of coverage under a group health insurance policy.

776 (b) The 6-month period to enroll in a Medicare supplement  
777 policy for an individual who is under 65 years of age and is  
778 eligible for Medicare by reason of disability or end-stage renal  
779 disease and otherwise eligible under subparagraph (a)1. or  
780 subparagraph (a)2. and first enrolled in Medicare Part B before  
781 October 1, 2009, begins on October 1, 2009.



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782 (c) A company that has offered Medicare supplement policies  
783 to individuals under 65 years of age who are eligible for  
784 Medicare by reason of disability or end-stage renal disease  
785 before October 1, 2009, may, for one time only, effect a rate  
786 schedule change that redefines the age bands of the premium  
787 classes without activating the period of discontinuance required  
788 by s. 627.410(6)(e)2.

789 (d) As a part of an insurer's rate filings, before and  
790 including the insurer's first rate filing for a block of policy  
791 forms in 2015, notwithstanding the provisions of s.  
792 627.410(6)(e)3., an insurer shall consider the experience of the  
793 policies or certificates for the premium classes including  
794 individuals under 65 years of age and eligible for Medicare by  
795 reason of disability or end-stage renal disease separately from  
796 the balance of the block so as not to affect the other premium  
797 classes. For filings in such time period only, credibility of  
798 that experience shall be as follows: if a block of policy forms  
799 has 1,250 or more policies or certificates in force in the age  
800 band including ages under 65 years of age, full or 100-percent  
801 credibility shall be given to the experience; and if fewer than  
802 250 policies or certificates are in force, no or zero-percent  
803 credibility shall be given. Linear interpolation shall be used  
804 for in-force amounts between the low and high values. Florida-  
805 only experience shall be used if it is 100-percent credible. If  
806 Florida-only experience is not 100-percent credible, a  
807 combination of Florida-only and nationwide experience shall be  
808 used. If Florida-only experience is zero-percent credible,  
809 nationwide experience shall be used. The insurer may file its  
810 initial rates and any rate adjustment based upon the experience



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811 of these policies or certificates or based upon expected claim  
812 experience using experience data of the same company, other  
813 companies in the same or other states, or using data publicly  
814 available from the Centers for Medicaid and Medicare Services if  
815 the insurer's combined Florida and nationwide experience is not  
816 100-percent credible, separate from the balance of all other  
817 Medicare supplement policies.

818  
819 A Medicare supplement policy issued to an individual under  
820 subparagraph (a)1. or subparagraph (a)2. may not exclude  
821 benefits based on a preexisting condition if the individual has  
822 a continuous period of creditable coverage, as defined in s.  
823 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of  
824 application for coverage.

825 (2) For both individual and group Medicare supplement  
826 policies:

827 (c) If a Medicare supplement policy or certificate replaces  
828 another Medicare supplement policy or certificate or creditable  
829 coverage as defined in s. 627.6562(3) ~~627.6561(5)~~, the replacing  
830 insurer shall waive any time periods applicable to preexisting  
831 conditions, waiting periods, elimination periods, and  
832 probationary periods in the new Medicare supplement policy for  
833 similar benefits to the extent such time was spent under the  
834 original policy, ~~subject to the requirements of s. 627.6561(6)-~~  
835 ~~(11)~~.

836 Section 19. Subsection (2) and paragraph (a) of subsection  
837 (40) of section 641.31, Florida Statutes, are amended to read:  
838 641.31 Health maintenance contracts.—

839 (2) The rates charged by any health maintenance



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840 organization to its subscribers shall not be excessive,  
841 inadequate, or unfairly discriminatory or follow a rating  
842 methodology that is inconsistent, indeterminate, or ambiguous or  
843 encourages misrepresentation or misunderstanding. ~~A law~~  
844 ~~restricting or limiting deductibles, coinsurance, copayments, or~~  
845 ~~annual or lifetime maximum payments shall not apply to any~~  
846 ~~health maintenance organization contract that provides coverage~~  
847 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~  
848 ~~individual or a group of 51 or more persons.~~ The commission, in  
849 accordance with generally accepted actuarial practice as applied  
850 to health maintenance organizations, may define by rule what  
851 constitutes excessive, inadequate, or unfairly discriminatory  
852 rates and may require whatever information it deems necessary to  
853 determine that a rate or proposed rate meets the requirements of  
854 this subsection.

855 (40)(a) Any group rate, rating schedule, or rating manual  
856 for a health maintenance organization policy, which provides  
857 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,  
858 filed with the office shall provide for an appropriate rebate of  
859 premiums paid in the last policy year, contract year, or  
860 calendar year when the majority of members of a health plan are  
861 enrolled in and have maintained participation in any health  
862 wellness, maintenance, or improvement program offered by the  
863 group contract holder. The group must provide evidence of  
864 demonstrative maintenance or improvement of his or her health  
865 status as determined by assessments of agreed-upon health status  
866 indicators between the group and the health insurer, including,  
867 but not limited to, reduction in weight, body mass index, and  
868 smoking cessation. Any rebate provided by the health maintenance



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869 organization is presumed to be appropriate unless credible data  
870 demonstrates otherwise, or unless the rebate program requires  
871 the insured to incur costs to qualify for the rebate which  
872 equals or exceeds the value of the rebate but the rebate may not  
873 exceed 10 percent of paid premiums.

874 Section 20. Section 641.31071, Florida Statutes, is amended  
875 to read:

876 641.31071 Preexisting conditions.—

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

878 (a) "Enrollment date" means, with respect to an individual  
879 covered under a group health maintenance organization contract,  
880 the date of enrollment of the individual in the plan or coverage  
881 or, if earlier, the first day of the waiting period of such  
882 enrollment.

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

886 1. The first period in which the individual is eligible to  
887 enroll under the plan.

888 2. A special enrollment period, as provided under s.  
889 641.31072.

890 (c) "Waiting period" means, with respect to a group health  
891 maintenance organization contract and an individual who is a  
892 potential participant or beneficiary under the contract, the  
893 period that must pass with respect to the individual before the  
894 individual is eligible to be covered for benefits under the  
895 terms of the contract.

896 (2) Subject to the exceptions specified in subsection (4),  
897 a health maintenance organization that offers group coverage,



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898 may, with respect to a participant or beneficiary, impose a  
899 preexisting condition exclusion only if:

900 (a) Such exclusion relates to a physical or mental  
901 condition, regardless of the cause of the condition, for which  
902 medical advice, diagnosis, care, or treatment was recommended or  
903 received within the 6-month period ending on the enrollment  
904 date;

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

908 (c) The period of any such preexisting condition exclusion  
909 is reduced by the aggregate of the periods of creditable  
910 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,  
911 applicable to the participant or beneficiary as of the  
912 enrollment date.

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

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

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

922 2. A child who is adopted or placed for adoption before  
923 attaining 18 years of age and who, as of the last day of the 30-  
924 day period beginning on the date of the adoption or placement  
925 for adoption, is covered under creditable coverage. This  
926 provision shall not apply to coverage before the date of such





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927 adoption or placement for adoption.

928 3. Pregnancy.

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

933 ~~(5) (a) The term "creditable coverage" means, with respect~~  
934 ~~to an individual, coverage of the individual under any of the~~  
935 ~~following:~~

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

938 ~~2. Health insurance coverage consisting of medical care,~~  
939 ~~provided directly, through insurance or reimbursement or~~  
940 ~~otherwise, and including terms and services paid for as medical~~  
941 ~~care, under any hospital or medical service policy or~~  
942 ~~certificate, hospital or medical service plan contract, or~~  
943 ~~health maintenance contract offered by a health insurance~~  
944 ~~issuer.~~

945 ~~3. Part A or part B of Title XVIII of the Social Security~~  
946 ~~Act.~~

947 ~~4. Title XIX of the Social Security Act, other than~~  
948 ~~coverage consisting solely of benefits under s. 1928.~~

949 ~~5. Chapter 55 of Title 10, United States Code.~~

950 ~~6. A medical care program of the Indian Health Service or~~  
951 ~~of a tribal organization.~~

952 ~~7. The Florida Comprehensive Health Association or another~~  
953 ~~state health benefit risk pool.~~

954 ~~8. A health plan offered under chapter 89 of Title 5,~~  
955 ~~United States Code.~~



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956 ~~9. A public health plan as defined by rule of the~~  
957 ~~commission. To the greatest extent possible, such rules must be~~  
958 ~~consistent with regulations adopted by the United States~~  
959 ~~Department of Health and Human Services.~~

960 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~  
961 ~~Act (22 U.S.C. s. 2504(e)).~~

962 ~~(b) Creditable coverage does not include coverage that~~  
963 ~~consists solely of one or more or any combination thereof of the~~  
964 ~~following excepted benefits:~~

965 ~~1. Coverage only for accident, or disability income~~  
966 ~~insurance, or any combination thereof.~~

967 ~~2. Coverage issued as a supplement to liability insurance.~~

968 ~~3. Liability insurance, including general liability~~  
969 ~~insurance and automobile liability insurance.~~

970 ~~4. Workers' compensation or similar insurance.~~

971 ~~5. Automobile medical payment insurance.~~

972 ~~6. Credit-only insurance.~~

973 ~~7. Coverage for onsite medical clinics.~~

974 ~~8. Other similar insurance coverage, specified in rules~~  
975 ~~adopted by the commission, under which benefits for medical care~~  
976 ~~are secondary or incidental to other insurance benefits. To the~~  
977 ~~greatest extent possible, such rules must be consistent with~~  
978 ~~regulations adopted by the United States Department of Health~~  
979 ~~and Human Services.~~

980 ~~(c) The following benefits are not subject to the~~  
981 ~~creditable coverage requirements, if offered separately;~~

982 ~~1. Limited scope dental or vision benefits.~~

983 ~~2. Benefits or long-term care, nursing home care, home~~  
984 ~~health care, community-based care, or any combination of these.~~



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985 ~~3. Such other similar, limited benefits as are specified in~~  
986 ~~rules adopted by the commission. To the greatest extent~~  
987 ~~possible, such rules must be consistent with regulations adopted~~  
988 ~~by the United States Department of Health and Human Services.~~

989 ~~(d) The following benefits are not subject to creditable~~  
990 ~~coverage requirements if offered as independent, noncoordinated~~  
991 ~~benefits:~~

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

993 ~~2. Hospital indemnity or other fixed indemnity insurance.~~

994 ~~(e) Benefits provided through Medicare supplemental health~~  
995 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~  
996 ~~Act, coverage supplemental to the coverage provided under~~  
997 ~~chapter 55 of Title 10, United States Code, and similar~~  
998 ~~supplemental coverage provided to coverage under a group health~~  
999 ~~plan are not considered creditable coverage if offered as a~~  
1000 ~~separate insurance policy.~~

1001 ~~(6) (a) A period of creditable coverage may not be counted,~~  
1002 ~~with respect to enrollment of an individual under a group health~~  
1003 ~~maintenance organization contract, if, after such period and~~  
1004 ~~before the enrollment date, there was a 63-day period during all~~  
1005 ~~of which the individual was not covered under any creditable~~  
1006 ~~coverage.~~

1007 ~~(b) Any period during which an individual is in a waiting~~  
1008 ~~period, or in an affiliation period as defined in subsection~~  
1009 ~~(9), for any coverage under a group health maintenance~~  
1010 ~~organization contract may not be taken into account in~~  
1011 ~~determining the 63-day period under paragraph (a) or paragraph~~  
1012 ~~(4) (b).~~

1013 ~~(7) (a) Except as otherwise provided under paragraph (b), a~~



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1014 ~~health maintenance organization shall count a period of~~  
1015 ~~creditable coverage without regard to the specific benefits~~  
1016 ~~covered under the period.~~

1017 ~~(b) A health maintenance organization may elect to count as~~  
1018 ~~creditable coverage, coverage of benefits within each of several~~  
1019 ~~classes or categories of benefits specified in rules adopted by~~  
1020 ~~the commission rather than as provided under paragraph (a). Such~~  
1021 ~~election shall be made on a uniform basis for all participants~~  
1022 ~~and beneficiaries. Under such election, a health maintenance~~  
1023 ~~organization shall count a period of creditable coverage with~~  
1024 ~~respect to any class or category of benefits if any level of~~  
1025 ~~benefits is covered within such class or category.~~

1026 ~~(c) In the case of an election with respect to a health~~  
1027 ~~maintenance organization under paragraph (b), the organization~~  
1028 ~~shall:~~

1029 ~~1. Prominently state in 10-point type or larger in any~~  
1030 ~~disclosure statements concerning the contract, and state to each~~  
1031 ~~enrollee at the time of enrollment under the contract, that the~~  
1032 ~~organization has made such election; and~~

1033 ~~2. Include in such statements a description of the effect~~  
1034 ~~of this election.~~

1035 ~~(8) (a) Periods of creditable coverage with respect to an~~  
1036 ~~individual shall be established through presentation of~~  
1037 ~~certifications described in this subsection or in such other~~  
1038 ~~manner as may be specified in rules adopted by the commission.~~

1039 ~~(b) A health maintenance organization that offers group~~  
1040 ~~coverage shall provide the certification described in paragraph~~  
1041 ~~(a):~~

1042 ~~1. At the time an individual ceases to be covered under the~~



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1043 ~~plan or otherwise becomes covered under a COBRA continuation~~  
1044 ~~provision or continuation pursuant to s. 627.6692.~~

1045 ~~2. In the case of an individual becoming covered under a~~  
1046 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~  
1047 ~~time the individual ceases to be covered under such a provision.~~

1048 ~~3. Upon the request on behalf of an individual made not~~  
1049 ~~later than 24 months after the date of cessation of the coverage~~  
1050 ~~described in this paragraph.~~

1051  
1052 ~~The certification under subparagraph 1. may be provided, to the~~  
1053 ~~extent practicable, at a time consistent with notices required~~  
1054 ~~under any applicable COBRA continuation provision or~~  
1055 ~~continuation pursuant to s. 627.6692.~~

1056 ~~(c) The certification is a written certification of:~~

1057 ~~1. The period of creditable coverage of the individual~~  
1058 ~~under the contract and the coverage, if any, under such COBRA~~  
1059 ~~continuation provision or continuation pursuant to s. 627.6692;~~  
1060 ~~and~~

1061 ~~2. The waiting period, if any, imposed with respect to the~~  
1062 ~~individual for any coverage under such contract.~~

1063 ~~(d) In the case of an election described in subsection (7)~~  
1064 ~~by a health maintenance organization, if the organization~~  
1065 ~~enrolls an individual for coverage under the plan and the~~  
1066 ~~individual provides a certification of coverage of the~~  
1067 ~~individual, as provided by this subsection:~~

1068 ~~1. Upon request of such health maintenance organization,~~  
1069 ~~the insurer or health maintenance organization that issued the~~  
1070 ~~certification provided by the individual shall promptly disclose~~  
1071 ~~to such requesting organization information on coverage of~~



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1072 ~~classes and categories of health benefits available under such~~  
1073 ~~insurer's or health maintenance organization's plan or coverage.~~

1074 ~~2. Such insurer or health maintenance organization may~~  
1075 ~~charge the requesting organization for the reasonable cost of~~  
1076 ~~disclosing such information.~~

1077 ~~(c) The commission shall adopt rules to prevent an~~  
1078 ~~insurer's or health maintenance organization's failure to~~  
1079 ~~provide information under this subsection with respect to~~  
1080 ~~previous coverage of an individual from adversely affecting any~~  
1081 ~~subsequent coverage of the individual under another group health~~  
1082 ~~plan or health maintenance organization coverage.~~

1083 ~~(9) (a) A health maintenance organization may provide for an~~  
1084 ~~affiliation period with respect to coverage through the~~  
1085 ~~organization only if:~~

1086 ~~1. No preexisting condition exclusion is imposed with~~  
1087 ~~respect to coverage through the organization;~~

1088 ~~2. The period is applied uniformly without regard to any~~  
1089 ~~health-status-related factors; and~~

1090 ~~3. Such period does not exceed 2 months or 3 months in the~~  
1091 ~~case of a late enrollee.~~

1092 ~~(b) For the purposes of this section, the term "affiliation~~  
1093 ~~period" means a period that, under the terms of the coverage~~  
1094 ~~offered by the health maintenance organization, must expire~~  
1095 ~~before the coverage becomes effective. The organization is not~~  
1096 ~~required to provide health care services or benefits during such~~  
1097 ~~period, and no premium may be charged to the participant or~~  
1098 ~~beneficiary for any coverage during the period. Such period~~  
1099 ~~begins on the enrollment date and runs concurrently with any~~  
1100 ~~waiting period under the plan.~~



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1101 ~~(c) As an alternative to the method authorized by paragraph~~  
1102 ~~(a), a health maintenance organization may address adverse~~  
1103 ~~selection in a method approved by the office.~~

1104 ~~(10) (a) Except as provided in paragraph (b), no period~~  
1105 ~~before July 1, 1996, shall be taken into account in determining~~  
1106 ~~creditable coverage.~~

1107 ~~(b) The commission shall adopt rules that provide a process~~  
1108 ~~whereby individuals who need to establish creditable coverage~~  
1109 ~~for periods before July 1, 1996, and who would have such~~  
1110 ~~coverage credited but for paragraph (a), may be given credit for~~  
1111 ~~creditable coverage for such periods through the presentation of~~  
1112 ~~documents or other means.~~

1113 ~~(11) Except as otherwise provided in this subsection, the~~  
1114 ~~requirements of paragraph (8) (b) shall apply to events that~~  
1115 ~~occur on or after July 1, 1996.~~

1116 ~~(a) In no case is a certification required to be provided~~  
1117 ~~under paragraph (8) (b) prior to June 1, 1997.~~

1118 ~~(b) In the case of an event that occurs on or after July 1,~~  
1119 ~~1996, and before October 1, 1996, a certification is not~~  
1120 ~~required to be provided under paragraph (8) (b), unless an~~  
1121 ~~individual, with respect to whom the certification is required~~  
1122 ~~to be made, requests such certification in writing.~~

1123 ~~(12) In the case of an individual who seeks to establish~~  
1124 ~~creditable coverage for any period for which certification is~~  
1125 ~~not required because it relates to an event occurring before~~  
1126 ~~July 1, 1996:~~

1127 ~~(a) The individual may present other creditable coverage in~~  
1128 ~~order to establish the period of creditable coverage.~~

1129 ~~(b) A health maintenance organization is not subject to any~~



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1130 ~~penalty or enforcement action with respect to the organization's~~  
1131 ~~crediting, or not crediting, such coverage if the organization~~  
1132 ~~has sought to comply in good faith with applicable provisions of~~  
1133 ~~this section.~~

1134 ~~(13) For purposes of subsection (10), any plan amendment~~  
1135 ~~made pursuant to a collective bargaining agreement relating to~~  
1136 ~~the plan which amends the plan solely to conform to any~~  
1137 ~~requirement of this section may not be treated as a termination~~  
1138 ~~of such collective bargaining agreement.~~

1139 Section 21. Subsections (1), (3), and (4) of section  
1140 641.31074, Florida Statutes, are amended to read:

1141 641.31074 Guaranteed renewability of coverage.—

1142 (1) Except as otherwise provided in this section, a health  
1143 maintenance organization that issues a ~~group~~ health insurance  
1144 contract must renew or continue in force such coverage at the  
1145 option of the contract holder.

1146 (3) (a) A health maintenance organization may discontinue  
1147 offering a particular contract form ~~for group coverage offered~~  
1148 ~~in the small group market or large group market~~ only if:

1149 1. The health maintenance organization provides notice to  
1150 each contract holder provided coverage of this form in such  
1151 market, and participants and beneficiaries covered under such  
1152 coverage, of such discontinuation at least 90 days prior to the  
1153 date of the nonrenewal of such coverage;

1154 2. The health maintenance organization offers to each  
1155 contract holder provided coverage of this form in such market  
1156 the option to purchase all, or in the case of the large group  
1157 market, any other health insurance coverage currently being  
1158 offered by the health maintenance organization in such market;





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1159 and

1160 3. In exercising the option to discontinue coverage of this  
1161 form and in offering the option of coverage under subparagraph  
1162 2., the health maintenance organization acts uniformly without  
1163 regard to the claims experience of those contract holders or any  
1164 health-status-related factor that relates to any participants or  
1165 beneficiaries covered or new participants or beneficiaries who  
1166 may become eligible for such coverage.

1167 (b)1. In any case in which a health maintenance  
1168 organization elects to discontinue offering all coverage in the  
1169 individual market, the small group market, ~~or~~ the large group  
1170 market, or any combination thereof ~~both,~~ in this state, coverage  
1171 may be discontinued by the insurer only if:

1172 a. The health maintenance organization provides notice to  
1173 the office and to each contract holder, and participants and  
1174 beneficiaries covered under such coverage, of such  
1175 discontinuation at least 180 days prior to the date of the  
1176 nonrenewal of such coverage; and

1177 b. All health insurance issued or delivered for issuance in  
1178 this state in such market is discontinued and coverage under  
1179 such health insurance coverage in such market is not renewed.

1180 2. In the case of a discontinuation under subparagraph 1.  
1181 in a market, the health maintenance organization may not provide  
1182 for the issuance of any health maintenance organization contract  
1183 coverage in the market in this state during the 5-year period  
1184 beginning on the date of the discontinuation of the last  
1185 insurance contract not renewed.

1186 (4) At the time of coverage renewal, a health maintenance  
1187 organization may modify the coverage for a product offered:



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- 1188 (a) In the large group market; ~~or~~  
1189 (b) In the small group market if, for coverage that is  
1190 available in such market other than only through one or more  
1191 bona fide associations, as defined in s. 627.6571(5), such  
1192 modification is consistent with s. 627.6699 and effective on a  
1193 uniform basis among group health plans with that product; or  
1194 (c) In the individual market if the modification is  
1195 consistent with the laws of this state and effective on a  
1196 uniform basis among all individuals with that policy form.

1197 Section 22. Section 641.312, Florida Statutes, is amended  
1198 to read:

1199 641.312 Scope.—The Office of Insurance Regulation may adopt  
1200 rules to administer the provisions of the National Association  
1201 of Insurance Commissioners' Uniform Health Carrier External  
1202 Review Model Act, issued by the National Association of  
1203 Insurance Commissioners and dated April 2010. This section does  
1204 not apply to a health maintenance contract that is subject to  
1205 the Subscriber Assistance Program under s. 408.7056 or to the  
1206 types of benefits or coverages provided under s. 627.6513(1)-  
1207 (14) s. ~~627.6561(5)(b)-(e)~~ issued in any market.

1208 Section 23. This act shall take effect July 1, 2016.