

By the Committees on Appropriations; and Banking and Insurance;
and Senator Detert

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1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 112.08, F.S.; authorizing
4 local governmental units to contract for certain group
5 insurance with a corporation not for profit whose
6 membership consists of specified local governmental
7 units; adding such a corporation not for profit as an
8 alternative entity that a local governmental unit must
9 contract with to administer certain insurance plans;
10 amending s. 408.909, F.S.; redefining the terms
11 "health care coverage" and "health flex plan
12 coverage"; amending s. 409.817, F.S.; deleting a
13 provision authorizing group insurance plans to impose
14 a certain preexisting condition exclusion; amending s.
15 624.123, F.S.; conforming a cross-reference; amending
16 s. 626.88, F.S.; revising the definition of the term
17 "administrator"; amending s. 627.402, F.S.; redefining
18 the term "nongrandfathered health plan"; amending s.
19 627.411, F.S.; deleting a provision relating to a
20 minimum loss ratio standard for specified health
21 insurance coverage; deleting provisions specifying
22 certain incurred claims; amending s. 627.6011, F.S.,
23 conforming a cross-reference; amending s. 627.602,
24 F.S.; conforming a cross-reference; amending s.
25 627.642, F.S.; revising the policies to which certain
26 outline of coverage requirements apply; amending s.
27 627.6425, F.S.; redefining the term "individual health
28 insurance"; revising applicability; amending s.
29 627.6487, F.S.; redefining terms; repealing s.
30 627.64871, F.S., relating to certification of
31 coverage; amending s. 627.6512, F.S.; revising a

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

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61 requirements relating to creditable coverage to
62 conform to changes made by the act; amending s.
63 641.31074; requiring a health maintenance organization
64 that issues a health insurance contract, rather than a
65 group health insurance contract, to renew or continue
66 in force such coverage at the contract holder's
67 option; revising conditions under which a health
68 maintenance organization may discontinue offering a
69 particular contract form; adding to the conditions
70 under which a health maintenance organization may, at
71 the time of coverage renewal, modify coverage for a
72 product offered; amending s. 641.312, F.S.; conforming
73 a cross-reference; providing an effective date.

74

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

76

77 Section 1. Paragraph (a) of subsection (2) of section
78 112.08, Florida Statutes, is amended to read:

79 112.08 Group insurance for public officers, employees, and
80 certain volunteers; physical examinations.-

81 (2) (a) Notwithstanding any general law or special act to
82 the contrary, every local governmental unit is authorized to
83 provide and pay out of its available funds for all or part of
84 the premium for life, health, accident, hospitalization, legal
85 expense, or annuity insurance, or all or any kinds of such
86 insurance, for the officers and employees of the local
87 governmental unit and for health, accident, hospitalization, and
88 legal expense insurance for the dependents of such officers and
89 employees upon a group insurance plan and, to that end, to enter

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90 into contracts with insurance companies or professional
91 administrators to provide such insurance or with a corporation
92 not for profit whose membership consists entirely of local
93 governmental units authorized to enter into risk management
94 consortiums under this subsection. Before entering any contract
95 for insurance, the local governmental unit shall advertise for
96 competitive bids; and such contract shall be let upon the basis
97 of such bids. If a contracting health insurance provider becomes
98 financially impaired as determined by the Office of Insurance
99 Regulation of the Financial Services Commission or otherwise
100 fails or refuses to provide the contracted-for coverage or
101 coverages, the local government may purchase insurance, enter
102 into risk management programs, or contract with third-party
103 administrators and may make such acquisitions by advertising for
104 competitive bids or by direct negotiations and contract. The
105 local governmental unit may undertake simultaneous negotiations
106 with those companies which have submitted reasonable and timely
107 bids and are found by the local governmental unit to be fully
108 qualified and capable of meeting all servicing requirements.
109 Each local governmental unit may self-insure any plan for
110 health, accident, and hospitalization coverage or enter into a
111 risk management consortium to provide such coverage, subject to
112 approval based on actuarial soundness by the Office of Insurance
113 Regulation; and each shall contract with an insurance company or
114 professional administrator qualified and approved by the office
115 or with a corporation not for profit whose membership consists
116 entirely of local governmental units authorized to enter into a
117 risk management consortium under this subsection to administer
118 such a plan.

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119 Section 2. Paragraph (d) of subsection (2) of section
120 408.909, Florida Statutes, is amended to read:

121 408.909 Health flex plans.—

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

123 (d) "Health care coverage" or "health flex plan coverage"
124 means health care services that are covered as benefits under an
125 approved health flex plan or that are otherwise provided, either
126 directly or through arrangements with other persons, via a
127 health flex plan on a prepaid per capita basis or on a prepaid
128 aggregate fixed-sum basis. The terms may also include one or
129 more of the excepted benefits under s. 627.6513(1)-(13) ~~s.~~
130 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
131 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
132 ~~as independent, noncoordinated benefits.~~

133 Section 3. Section 409.817, Florida Statutes, is amended to
134 read:

135 409.817 Approval of health benefits coverage; financial
136 assistance.—In order for health insurance coverage to qualify
137 for premium assistance payments for an eligible child under ss.
138 409.810-409.821, the health benefits coverage must:

139 (1) Be certified by the Office of Insurance Regulation of
140 the Financial Services Commission under s. 409.818 as meeting,
141 exceeding, or being actuarially equivalent to the benchmark
142 benefit plan;

143 (2) Be guarantee issued;

144 (3) Be community rated;

145 (4) Not impose any preexisting condition exclusion for
146 covered benefits; ~~however, group health insurance plans may~~
147 ~~permit the imposition of a preexisting condition exclusion, but~~

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148 ~~only insofar as it is permitted under s. 627.6561;~~

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

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

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

155 Section 4. Paragraph (b) of subsection (1) of section
156 624.123, Florida Statutes, is amended to read:

157 624.123 Certain international health insurance policies;
158 exemption from code.—

159 (1) International health insurance policies and
160 applications may be solicited and sold in this state at any
161 international airport to a resident of a foreign country. Such
162 international health insurance policies shall be solicited and
163 sold only by a licensed health insurance agent and underwritten
164 only by an admitted insurer. For purposes of this subsection:

165 (b) "International health insurance policy" means health
166 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2. ~~s.~~
167 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
168 only a resident of a foreign country on an annual basis.

169 Section 5. Paragraph (t) is added to subsection (1) of
170 section 626.88, Florida Statutes, to read:

171 626.88 Definitions.—For the purposes of this part, the
172 term:

173 (1) "Administrator" is any person who directly or
174 indirectly solicits or effects coverage of, collects charges or
175 premiums from, or adjusts or settles claims on residents of this
176 state in connection with authorized commercial self-insurance

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177 funds or with insured or self-insured programs which provide
 178 life or health insurance coverage or coverage of any other
 179 expenses described in s. 624.33(1) or any person who, through a
 180 health care risk contract as defined in s. 641.234 with an
 181 insurer or health maintenance organization, provides billing and
 182 collection services to health insurers and health maintenance
 183 organizations on behalf of health care providers, other than any
 184 of the following persons:

185 (t) A corporation not for profit whose membership consists
 186 entirely of local governmental units authorized to enter into
 187 risk management consortiums under s. 112.08.

188
 189 A person who provides billing and collection services to health
 190 insurers and health maintenance organizations on behalf of
 191 health care providers shall comply with the provisions of ss.
 192 627.6131, 641.3155, and 641.51(4).

193 Section 6. Subsection (2) of section 627.402, Florida
 194 Statutes, is amended to read:

195 627.402 Definitions.—As used in this part, the term:

196 (2) "Nongrandfathered health plan" is a health insurance
 197 policy or health maintenance organization contract that is not a
 198 grandfathered health plan and does not provide the benefits or
 199 coverages specified under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)~~
 200 ~~(e)~~.

201 Section 7. Subsection (3) of section 627.411, Florida
 202 Statutes, is amended to read:

203 627.411 Grounds for disapproval.—

204 ~~(3)(a) For health insurance coverage as described in s.~~
 205 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~

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206 ~~claims to earned premium for the form shall be 65 percent.~~

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

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

213 ~~2. Claims do not include state assessments, taxes, company~~
214 ~~expenses, or any expense incurred by the company for the cost of~~
215 ~~adjusting and settling a claim, including the review,~~
216 ~~qualification, oversight, management, or monitoring of a claim~~
217 ~~or incentives or compensation to providers for other than the~~
218 ~~provisions of health care services.~~

219 ~~3. A company may at its discretion include costs that are~~
220 ~~demonstrated to reduce claims, such as fraud intervention~~
221 ~~programs or case management costs, which are identified in each~~
222 ~~filing, are demonstrated to reduce claims costs, and do not~~
223 ~~result in increasing the experience period loss ratio by more~~
224 ~~than 5 percent.~~

225 ~~4. For scheduled claim payments, such as disability income~~
226 ~~or long-term care, the incurred claims shall be the present~~
227 ~~value of the benefit payments discounted for continuance and~~
228 ~~interest.~~

229 Section 8. Section 627.6011, Florida Statutes, is amended
230 to read:

231 627.6011 Mandated coverages.—Mandatory health benefits
232 regulated under this chapter are not intended to apply to the
233 types of health benefit plans listed in s. 627.6513(1)-(14) ~~s.~~
234 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically

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235 designated otherwise. For purposes of this section, the term
236 "mandatory health benefits" means those benefits set forth in
237 ss. 627.6401-627.64193, and any other mandatory treatment or
238 health coverages or benefits enacted on or after July 1, 2012.

239 Section 9. Paragraph (h) of subsection (1) of section
240 627.602, Florida Statutes, is amended to read:

241 627.602 Scope, format of policy.-

242 (1) Each health insurance policy delivered or issued for
243 delivery to any person in this state must comply with all
244 applicable provisions of this code and all of the following
245 requirements:

246 (h) Section 641.312 and the provisions of the Employee
247 Retirement Income Security Act of 1974, as implemented by 29
248 C.F.R. s. 2560.503-1, relating to internal grievances. This
249 paragraph does not apply to a health insurance policy that is
250 subject to the Subscriber Assistance Program under s. 408.7056
251 or to the types of benefits or coverages provided under s.
252 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.

253 Section 10. Subsection (1) of section 627.642, Florida
254 Statutes, is amended to read:

255 627.642 Outline of coverage.-

256 (1) A policy offering benefits defined in s. 627.6513(1)-
257 (14) may not ~~No individual or family accident and health~~
258 ~~insurance policy shall~~ be delivered, or issued for delivery, in
259 this state unless:

260 (a) It is accompanied by an appropriate outline of
261 coverage; or

262 (b) An appropriate outline of coverage is completed and
263 delivered to the applicant at the time application is made, and

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264 an acknowledgment of receipt or certificate of delivery of such
265 outline is provided to the insurer with the application.

266

267 In the case of a direct response, such as a written application
268 to the insurance company from an applicant, the outline of
269 coverage shall accompany the policy when issued.

270 Section 11. Subsections (1), (6), and (7) of section
271 627.6425, Florida Statutes, are amended, to read:

272 627.6425 Renewability of individual coverage.—

273 (1) Except as otherwise provided in this section, an
274 insurer that provides individual health insurance coverage to an
275 individual shall renew or continue in force such coverage at the
276 option of the individual. For the purpose of this section, the
277 term "individual health insurance" means health insurance
278 coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~,
279 offered to an individual in this state, including certificates
280 of coverage offered to individuals in this state as part of a
281 group policy issued to an association outside this state, but
282 the term does not include short-term limited duration insurance
283 or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
284 ~~(6) or subsection (7).~~

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

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

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293 Section 12. Paragraph (b) of subsection (2) and subsection
294 (3) of section 627.6487, Florida Statutes, are amended to read:

295 627.6487 Guaranteed availability of individual health
296 insurance coverage to eligible individuals.-

297 (2) For the purposes of this section:

298 (b) "Individual health insurance" means health insurance,
299 as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered
300 to an individual, including certificates of coverage offered to
301 individuals in this state as part of a group policy issued to an
302 association outside this state, but the term does not include
303 short-term limited duration insurance or excepted benefits
304 specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the~~
305 ~~benefits are provided under a separate policy, certificate, or~~
306 ~~contract, the term does not include excepted benefits specified~~
307 ~~in s. 627.6561(5)(c), (d), or (e).~~

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

310 (a)1. For whom, as of the date on which the individual
311 seeks coverage under this section, the aggregate of the periods
312 of creditable coverage, as defined in s. 627.6562(3) ~~s.~~
313 ~~627.6561(5) and (6),~~ is 18 or more months; and

314 2.a. Whose most recent prior creditable coverage was under
315 a group health plan, governmental plan, or church plan, or
316 health insurance coverage offered in connection with any such
317 plan; or

318 b. Whose most recent prior creditable coverage was under an
319 individual plan issued in this state by a health insurer or
320 health maintenance organization, which coverage is terminated
321 due to the insurer or health maintenance organization becoming

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322 insolvent or discontinuing the offering of all individual
323 coverage in the State of Florida, or due to the insured no
324 longer living in the service area in the State of Florida of the
325 insurer or health maintenance organization that provides
326 coverage through a network plan in the State of Florida;

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

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

330 2. A conversion policy or contract issued by an authorized
331 insurer or health maintenance organization under s. 627.6675 or
332 s. 641.3921, respectively, offered to an individual who is no
333 longer eligible for coverage under either an insured or self-
334 insured employer plan;

335 3. Part A or part B of Title XVIII of the Social Security
336 Act; or

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

340 (c) With respect to whom the most recent coverage within
341 the coverage period described in paragraph (a) was not
342 terminated based on a factor described in s. 627.6571(2)(a) or
343 (b), relating to nonpayment of premiums or fraud, unless such
344 nonpayment of premiums or fraud was due to acts of an employer
345 or person other than the individual;

346 (d) Who, having been offered the option of continuation
347 coverage under a COBRA continuation provision or under s.
348 627.6692, elected such coverage; and

349 (e) Who, if the individual elected such continuation
350 provision, has exhausted such continuation coverage under such

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351 provision or program.

352 Section 13. Section 627.64871, Florida Statutes, is
353 repealed.

354 Section 14. Section 627.6512, Florida Statutes, is amended
355 to read:

356 627.6512 Exemption of certain group health insurance
357 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571
358 do not apply to:

359 (1) any group insurance policy in relation to its provision
360 of ~~excepted~~ benefits described in s. 627.6513(1)-(14)
361 ~~627.6561(5)(b).~~

362 (2) ~~Any group health insurance policy in relation to its~~
363 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
364 ~~if the benefits:~~

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

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

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

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

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

376 (c) ~~Such benefits are paid with respect to an event without~~
377 ~~regard to whether benefits are provided with respect to such an~~
378 ~~event under any group health policy maintained by the same~~
379 ~~policyholder.~~

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380 ~~(4) Any group health policy in relation to its provision of~~
381 ~~excepted benefits described in s. 627.6561(5) (e), if the~~
382 ~~benefits are provided under a separate policy, certificate, or~~
383 ~~contract of insurance.~~

384 Section 15. Section 627.6513, Florida Statutes, is amended
385 to read:

386 627.6513 Scope.—Section 641.312 and the provisions of the
387 Employee Retirement Income Security Act of 1974, as implemented
388 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
389 apply to all group health insurance policies issued under this
390 part. This section does not apply to a group health insurance
391 policy that is subject to the Subscriber Assistance Program in
392 s. 408.7056 or to: the types of benefits or coverages provided
393 under s. 627.6561(5) (b)–(e) issued in any market.

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

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

397 (3) Liability insurance, including general liability
398 insurance and automobile liability insurance.

399 (4) Workers' compensation or similar insurance.

400 (5) Automobile medical payment insurance.

401 (6) Credit-only insurance.

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

404 (8) Other similar insurance coverage, specified in rules
405 adopted by the commission, under which benefits for medical care
406 are secondary or incidental to other insurance benefits. To the
407 extent possible, such rules must be consistent with regulations
408 adopted by the United States Department of Health and Human

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409 Services.

410 (9) Limited scope dental or vision benefits, if offered
411 separately.

412 (10) Benefits for long-term care, nursing home care, home
413 health care, or community-based care, or any combination
414 thereof, if offered separately.

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

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

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

421 (14) Benefits provided through a Medicare supplemental
422 health insurance policy, as defined under s. 1882(g)(1) of the
423 Social Security Act, coverage supplemental to the coverage
424 provided under 10 U.S.C. chapter 55, and similar supplemental
425 coverage provided to coverage under a group health plan, which
426 are offered as a separate insurance policy and as independent,
427 noncoordinated benefits.

428 Section 16. Section 627.6561, Florida Statutes, is amended
429 to read:

430 627.6561 Preexisting conditions.—

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

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

436 (b) "Late enrollee" means, with respect to coverage under a
437 group health policy, a participant or beneficiary who enrolls

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438 under the policy other than during:

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

441 2. A special enrollment period, as provided under s.
442 627.65615.

443 (c) "Waiting period" means, with respect to a group health
444 policy and an individual who is a potential participant or
445 beneficiary of the policy, the period that must pass with
446 respect to the individual before the individual is eligible to
447 be covered for benefits under the terms of the policy.

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

452 (a) Such exclusion relates to a physical or mental
453 condition, regardless of the cause of the condition, for which
454 medical advice, diagnosis, care, or treatment was recommended or
455 received within the 6-month period ending on the enrollment
456 date;

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

460 (c) The period of any such preexisting condition exclusion
461 is reduced by the aggregate of the periods of creditable
462 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
463 applicable to the participant or beneficiary as of the
464 enrollment date.

465 (3) Genetic information may not be treated as a condition
466 described in paragraph (2) (a) in the absence of a diagnosis of

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467 the condition related to such information.

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

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

474 2. A child who is adopted or placed for adoption before
475 attaining 18 years of age and who, as of the last day of the 30-
476 day period beginning on the date of the adoption or placement
477 for adoption, is covered under creditable coverage. This
478 provision does not apply to coverage before the date of such
479 adoption or placement for adoption.

480 3. Pregnancy.

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

484 ~~(5) (a) The term, "creditable coverage," means, with respect~~
485 ~~to an individual, coverage of the individual under any of the~~
486 ~~following:~~

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

489 ~~2. Health insurance coverage consisting of medical care,~~
490 ~~provided directly, through insurance or reimbursement, or~~
491 ~~otherwise and including terms and services paid for as medical~~
492 ~~care, under any hospital or medical service policy or~~
493 ~~certificate, hospital or medical service plan contract, or~~
494 ~~health maintenance contract offered by a health insurance~~
495 ~~issuer.~~

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496 ~~3. Part A or part B of Title XVIII of the Social Security~~
497 ~~Act.~~

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

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

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

503 ~~7. The Florida Comprehensive Health Association or another~~
504 ~~state health benefit risk pool.~~

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

507 ~~9. A public health plan as defined by rules adopted by the~~
508 ~~commission. To the greatest extent possible, such rules must be~~
509 ~~consistent with regulations adopted by the United States~~
510 ~~Department of Health and Human Services.~~

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

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

516 ~~1. Coverage only for accident, or disability income~~
517 ~~insurance, or any combination thereof.~~

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

519 ~~3. Liability insurance, including general liability~~
520 ~~insurance and automobile liability insurance.~~

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

522 ~~5. Automobile medical payment insurance.~~

523 ~~6. Credit-only insurance.~~

524 ~~7. Coverage for onsite medical clinics, including prepaid~~

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525 ~~health clinics under part II of chapter 641.~~

526 ~~8. Other similar insurance coverage, specified in rules~~
527 ~~adopted by the commission, under which benefits for medical care~~
528 ~~are secondary or incidental to other insurance benefits. To the~~
529 ~~extent possible, such rules must be consistent with regulations~~
530 ~~adopted by the United States Department of Health and Human~~
531 ~~Services.~~

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

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

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

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

539 ~~(d) The following benefits are not subject to creditable~~
540 ~~coverage requirements if offered as independent, noncoordinated~~
541 ~~benefits:~~

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

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

544 ~~(e) Benefits provided through a Medicare supplemental~~
545 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~
546 ~~Security Act, coverage supplemental to the coverage provided~~
547 ~~under chapter 55 of Title 10, United States Code, and similar~~
548 ~~supplemental coverage provided to coverage under a group health~~
549 ~~plan are not considered creditable coverage if offered as a~~
550 ~~separate insurance policy.~~

551 ~~(6)(a) A period of creditable coverage may not be counted,~~
552 ~~with respect to enrollment of an individual under a group health~~
553 ~~plan, if, after such period and before the enrollment date,~~

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554 ~~there was a 63-day period during all of which the individual was~~
555 ~~not covered under any creditable coverage.~~

556 ~~(b) Any period during which an individual is in a waiting~~
557 ~~period for any coverage under a group health plan or for group~~
558 ~~health insurance coverage may not be taken into account in~~
559 ~~determining the 63-day period under paragraph (a) or paragraph~~
560 ~~(4)(b).~~

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

564 ~~(b) An insurer may elect to count, as creditable coverage,~~
565 ~~coverage of benefits within each of several classes or~~
566 ~~categories of benefits specified in rules adopted by the~~
567 ~~commission rather than as provided under paragraph (a). To the~~
568 ~~extent possible, such rules must be consistent with regulations~~
569 ~~adopted by the United States Department of Health and Human~~
570 ~~Services. Such election shall be made on a uniform basis for all~~
571 ~~participants and beneficiaries. Under such election, an insurer~~
572 ~~shall count a period of creditable coverage with respect to any~~
573 ~~class or category of benefits if any level of benefits is~~
574 ~~covered within such class or category.~~

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

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

581 ~~2. Include in such statements a description of the effect~~
582 ~~of this election.~~

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583 ~~(8)(a) Periods of creditable coverage with respect to an~~
584 ~~individual shall be established through presentation of~~
585 ~~certifications described in this subsection or in such other~~
586 ~~manner as is specified in rules adopted by the commission. To~~
587 ~~the extent possible, such rules must be consistent with~~
588 ~~regulations adopted by the United States Department of Health~~
589 ~~and Human Services.~~

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

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

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

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

601
602 ~~The certification under subparagraph 1. may be provided, to the~~
603 ~~extent practicable, at a time consistent with notices required~~
604 ~~under any applicable COBRA continuation provision or~~
605 ~~continuation pursuant to s. 627.6692.~~

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

608 ~~1. The period of creditable coverage of the individual~~
609 ~~under the policy and the coverage, if any, under such COBRA~~
610 ~~continuation provision or continuation pursuant to s. 627.6692;~~
611 ~~and~~

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

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

618 ~~1. Upon request of such insurer, the insurer that issued~~
619 ~~the certification provided by the individual shall promptly~~
620 ~~disclose to such requesting plan or insurer information on~~
621 ~~coverage of classes and categories of health benefits available~~
622 ~~under such insurer's plan or coverage.~~

623 ~~2. Such insurer may charge the requesting insurer for the~~
624 ~~reasonable cost of disclosing such information.~~

625 ~~(e) The commission shall adopt rules to prevent an~~
626 ~~insurer's failure to provide information under this subsection~~
627 ~~with respect to previous coverage of an individual from~~
628 ~~adversely affecting any subsequent coverage of the individual~~
629 ~~under another group health plan or health insurance coverage. To~~
630 ~~the greatest extent possible, such rules must be consistent with~~
631 ~~regulations adopted by the United States Department of Health~~
632 ~~and Human Services.~~

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

636 ~~(b) The commission shall adopt rules that provide a process~~
637 ~~whereby individuals who need to establish creditable coverage~~
638 ~~for periods before July 1, 1996, and who would have such~~
639 ~~coverage credited but for paragraph (a), may be given credit for~~
640 ~~creditable coverage for such periods through the presentation of~~

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641 ~~documents or other means. To the greatest extent possible, such~~
642 ~~rules must be consistent with regulations adopted by the United~~
643 ~~States Department of Health and Human Services.~~

644 ~~(10) Except as otherwise provided in this subsection,~~
645 ~~paragraph (8) (b) applies to events that occur on or after July~~
646 ~~1, 1996.~~

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

649 ~~(b) In the case of an event that occurred on or after July~~
650 ~~1, 1996, and before October 1, 1996, a certification is not~~
651 ~~required to be provided under paragraph (8) (b), unless an~~
652 ~~individual, with respect to whom the certification is required~~
653 ~~to be made, requests such certification in writing.~~

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

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

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

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

669 ~~(13) This section does not apply to any health insurance~~

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670 ~~coverage in relation to its provision of excepted benefits~~
671 ~~described in paragraph (5) (b).~~

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

677 ~~(15) This section applies to health insurance coverage~~
678 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
679 ~~1997.~~

680 Section 17. Subsection (3) of section 627.6562, Florida
681 Statutes, is amended to read:

682 627.6562 Dependent coverage.—

683 (3) If, pursuant to subsection (2), a child is provided
684 coverage under the parent's policy after the end of the calendar
685 year in which the child reaches age 25 and coverage for the
686 child is subsequently terminated, the child is not eligible to
687 be covered under the parent's policy unless the child was
688 continuously covered by other creditable coverage without a gap
689 in coverage of more than 63 days.

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

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

696 2. Health insurance coverage consisting of medical care
697 provided directly through insurance or reimbursement or
698 otherwise, and including terms and services paid for as medical

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699 care, under any hospital or medical service policy or
700 certificate, hospital or medical service plan contract, or
701 health maintenance contract offered by a health insurance
702 issuer.

703 3. Part A or part B of Title XVIII of the Social Security
704 Act.

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

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

708 6. A medical care program of the Indian Health Service or
709 of a tribal organization.

710 7. The Florida Comprehensive Health Association or another
711 state health benefit risk pool.

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

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

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

719 (b) Creditable coverage does not include coverage that
720 consists of one or more, or any combination thereof, of the
721 following excepted benefits:

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

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

725 3. Liability insurance, including general liability
726 insurance and automobile liability insurance.

727 4. Workers' compensation or similar insurance.

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- 728 5. Automobile medical payment insurance.
- 729 6. Credit-only insurance.
- 730 7. Coverage for onsite medical clinics, including prepaid
731 health clinics under part II of chapter 641.
- 732 8. Other similar insurance coverage specified in rules
733 adopted by the commission under which benefits for medical care
734 are secondary or incidental to other insurance benefits. To the
735 extent possible, such rules must be consistent with regulations
736 adopted by the United States Department of Health and Human
737 Services.
- 738 (c) The following benefits are not subject to the
739 creditable coverage requirements, if offered separately:
- 740 1. Limited scope dental or vision benefits.
- 741 2. Benefits for long-term care, nursing home care, home
742 health care, community-based care, or any combination thereof.
- 743 3. Other similar, limited benefits specified in rules
744 adopted by the commission.
- 745 (d) The following benefits are not subject to creditable
746 coverage requirements if offered as independent, noncoordinated
747 benefits:
- 748 1. Coverage only for a specified disease or illness.
- 749 2. Hospital indemnity or other fixed indemnity insurance.
- 750 (e) Benefits provided through a Medicare supplemental
751 health insurance policy, as defined under s. 1882(g)(1) of the
752 Social Security Act, coverage supplemental to the coverage
753 provided under 10 U.S.C. chapter 55, and similar supplemental
754 coverage provided to coverage under a group health plan are not
755 considered creditable coverage if offered as a separate
756 insurance policy.

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757 Section 18. Subsection (1) of section 627.65626, Florida
758 Statutes, is amended to read:

759 627.65626 Insurance rebates for healthy lifestyles.—

760 (1) Any rate, rating schedule, or rating manual for a
761 health insurance policy that provides creditable coverage as
762 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
763 shall provide for an appropriate rebate of premiums paid in the
764 last policy year, contract year, or calendar year when the
765 majority of members of a health plan have enrolled and
766 maintained participation in any health wellness, maintenance, or
767 improvement program offered by the group policyholder and health
768 plan. The rebate may be based upon premiums paid in the last
769 calendar year or policy year. The group must provide evidence of
770 demonstrative maintenance or improvement of the enrollees'
771 health status as determined by assessments of agreed-upon health
772 status indicators between the policyholder and the health
773 insurer, including, but not limited to, reduction in weight,
774 body mass index, and smoking cessation. The group or health
775 insurer may contract with a third-party administrator to
776 assemble and report the health status required in this
777 subsection between the policyholder and the health insurer. Any
778 rebate provided by the health insurer is presumed to be
779 appropriate unless credible data demonstrates otherwise, or
780 unless the rebate program requires the insured to incur costs to
781 qualify for the rebate which equal or exceed the value of the
782 rebate, but the rebate may not exceed 10 percent of paid
783 premiums.

784 Section 19. Paragraphs (e) and (1) of subsection (3) and
785 paragraph (d) of subsection (5) of section 627.6699, Florida

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786 Statutes, are amended to read:

787 627.6699 Employee Health Care Access Act.—

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

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

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

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

797 2. A special enrollment period, as provided under s.
798 627.65615 as defined under s. 627.6561(1)(b).

799 (5) AVAILABILITY OF COVERAGE.—

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

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

806 ~~2. Paragraph (c) applies to health benefit plans issued to~~
807 ~~a small employer who has two or more eligible employees and to~~
808 ~~health benefit plans that are issued to a small employer who has~~
809 ~~fewer than two eligible employees and that cover an employee who~~
810 ~~has had creditable coverage continually to a date not more than~~
811 ~~63 days before the effective date of the new coverage.~~

812 2.3. For health benefit plans that are issued to a small
813 employer who has fewer than two employees and that cover an
814 employee who has not been continually covered by creditable

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815 coverage within 63 days before the effective date of the new
816 coverage, preexisting condition provisions must not exclude
817 coverage for a period beyond 24 months following the employee's
818 effective date of coverage and may relate only to:

819 a. Conditions that, during the 24-month period immediately
820 preceding the effective date of coverage, had manifested
821 themselves in such a manner as would cause an ordinarily prudent
822 person to seek medical advice, diagnosis, care, or treatment or
823 for which medical advice, diagnosis, care, or treatment was
824 recommended or received; or

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

826 Section 20. Subsection (1) and paragraph (c) of subsection
827 (2) of section 627.6741, Florida Statutes, are amended to read:
828 627.6741 Issuance, cancellation, nonrenewal, and
829 replacement.—

830 (1) (a) An insurer issuing Medicare supplement policies in
831 this state shall offer the opportunity of enrolling in a
832 Medicare supplement policy, without conditioning the issuance or
833 effectiveness of the policy on, and without discriminating in
834 the price of the policy based on, the medical or health status
835 or receipt of health care by the individual:

836 1. To any individual who is 65 years of age or older, or
837 under 65 years of age and eligible for Medicare by reason of
838 disability or end-stage renal disease, and who resides in this
839 state, upon the request of the individual during the 6-month
840 period beginning with the first month in which the individual
841 has attained 65 years of age and is enrolled in Medicare Part B,
842 or is eligible for Medicare by reason of a disability or end-
843 stage renal disease, and is enrolled in Medicare Part B; or

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

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

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

863 (d) As a part of an insurer's rate filings, before and
864 including the insurer's first rate filing for a block of policy
865 forms in 2015, notwithstanding the provisions of s.
866 627.410(6)(e)3., an insurer shall consider the experience of the
867 policies or certificates for the premium classes including
868 individuals under 65 years of age and eligible for Medicare by
869 reason of disability or end-stage renal disease separately from
870 the balance of the block so as not to affect the other premium
871 classes. For filings in such time period only, credibility of
872 that experience shall be as follows: if a block of policy forms

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873 has 1,250 or more policies or certificates in force in the age
874 band including ages under 65 years of age, full or 100-percent
875 credibility shall be given to the experience; and if fewer than
876 250 policies or certificates are in force, no or zero-percent
877 credibility shall be given. Linear interpolation shall be used
878 for in-force amounts between the low and high values. Florida-
879 only experience shall be used if it is 100-percent credible. If
880 Florida-only experience is not 100-percent credible, a
881 combination of Florida-only and nationwide experience shall be
882 used. If Florida-only experience is zero-percent credible,
883 nationwide experience shall be used. The insurer may file its
884 initial rates and any rate adjustment based upon the experience
885 of these policies or certificates or based upon expected claim
886 experience using experience data of the same company, other
887 companies in the same or other states, or using data publicly
888 available from the Centers for Medicaid and Medicare Services if
889 the insurer's combined Florida and nationwide experience is not
890 100-percent credible, separate from the balance of all other
891 Medicare supplement policies.

892

893 A Medicare supplement policy issued to an individual under
894 subparagraph (a)1. or subparagraph (a)2. may not exclude
895 benefits based on a preexisting condition if the individual has
896 a continuous period of creditable coverage, as defined in s.
897 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
898 application for coverage.

899 (2) For both individual and group Medicare supplement
900 policies:

901 (c) If a Medicare supplement policy or certificate replaces

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902 another Medicare supplement policy or certificate or creditable
903 coverage as defined in s. 627.6562(3) ~~627.6561(5)~~, the replacing
904 insurer shall waive any time periods applicable to preexisting
905 conditions, waiting periods, elimination periods, and
906 probationary periods in the new Medicare supplement policy for
907 similar benefits to the extent such time was spent under the
908 original policy, ~~subject to the requirements of s. 627.6561(6)-~~
909 ~~(11)~~.

910 Section 21. Subsection (2) and paragraph (a) of subsection
911 (40) of section 641.31, Florida Statutes, are amended to read:

912 641.31 Health maintenance contracts.—

913 (2) The rates charged by any health maintenance
914 organization to its subscribers shall not be excessive,
915 inadequate, or unfairly discriminatory or follow a rating
916 methodology that is inconsistent, indeterminate, or ambiguous or
917 encourages misrepresentation or misunderstanding. ~~A law~~
918 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
919 ~~annual or lifetime maximum payments shall not apply to any~~
920 ~~health maintenance organization contract that provides coverage~~
921 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
922 ~~individual or a group of 51 or more persons.~~ The commission, in
923 accordance with generally accepted actuarial practice as applied
924 to health maintenance organizations, may define by rule what
925 constitutes excessive, inadequate, or unfairly discriminatory
926 rates and may require whatever information it deems necessary to
927 determine that a rate or proposed rate meets the requirements of
928 this subsection.

929 (40) (a) Any group rate, rating schedule, or rating manual
930 for a health maintenance organization policy, which provides

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931 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
932 filed with the office shall provide for an appropriate rebate of
933 premiums paid in the last policy year, contract year, or
934 calendar year when the majority of members of a health plan are
935 enrolled in and have maintained participation in any health
936 wellness, maintenance, or improvement program offered by the
937 group contract holder. The group must provide evidence of
938 demonstrative maintenance or improvement of his or her health
939 status as determined by assessments of agreed-upon health status
940 indicators between the group and the health insurer, including,
941 but not limited to, reduction in weight, body mass index, and
942 smoking cessation. Any rebate provided by the health maintenance
943 organization is presumed to be appropriate unless credible data
944 demonstrates otherwise, or unless the rebate program requires
945 the insured to incur costs to qualify for the rebate which
946 equals or exceeds the value of the rebate but the rebate may not
947 exceed 10 percent of paid premiums.

948 Section 22. Section 641.31071, Florida Statutes, is amended
949 to read:

950 641.31071 Preexisting conditions.—

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

952 (a) "Enrollment date" means, with respect to an individual
953 covered under a group health maintenance organization contract,
954 the date of enrollment of the individual in the plan or coverage
955 or, if earlier, the first day of the waiting period of such
956 enrollment.

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

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960 1. The first period in which the individual is eligible to
961 enroll under the plan.

962 2. A special enrollment period, as provided under s.
963 641.31072.

964 (c) "Waiting period" means, with respect to a group health
965 maintenance organization contract and an individual who is a
966 potential participant or beneficiary under the contract, the
967 period that must pass with respect to the individual before the
968 individual is eligible to be covered for benefits under the
969 terms of the contract.

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

974 (a) Such exclusion relates to a physical or mental
975 condition, regardless of the cause of the condition, for which
976 medical advice, diagnosis, care, or treatment was recommended or
977 received within the 6-month period ending on the enrollment
978 date;

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

982 (c) The period of any such preexisting condition exclusion
983 is reduced by the aggregate of the periods of creditable
984 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
985 applicable to the participant or beneficiary as of the
986 enrollment date.

987 (3) Genetic information shall not be treated as a condition
988 described in paragraph (2)(a) in the absence of a diagnosis of

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989 the condition related to such information.

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

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

996 2. A child who is adopted or placed for adoption before
997 attaining 18 years of age and who, as of the last day of the 30-
998 day period beginning on the date of the adoption or placement
999 for adoption, is covered under creditable coverage. This
1000 provision shall not apply to coverage before the date of such
1001 adoption or placement for adoption.

1002 3. Pregnancy.

1003 (b) Subparagraphs (a)1. and 2. do not apply to an
1004 individual after the end of the first 63-day period during all
1005 of which the individual was not covered under any creditable
1006 coverage.

1007 ~~(5) (a) The term "creditable coverage" means, with respect~~
1008 ~~to an individual, coverage of the individual under any of the~~
1009 ~~following:~~

1010 ~~1. A group health plan, as defined in s. 2791 of the Public~~
1011 ~~Health Service Act.~~

1012 ~~2. Health insurance coverage consisting of medical care,~~
1013 ~~provided directly, through insurance or reimbursement or~~
1014 ~~otherwise, and including terms and services paid for as medical~~
1015 ~~care, under any hospital or medical service policy or~~
1016 ~~certificate, hospital or medical service plan contract, or~~
1017 ~~health maintenance contract offered by a health insurance~~

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- 1018 issuer.
- 1019 ~~3. Part A or part B of Title XVIII of the Social Security~~
- 1020 ~~Act.~~
- 1021 ~~4. Title XIX of the Social Security Act, other than~~
- 1022 ~~coverage consisting solely of benefits under s. 1928.~~
- 1023 ~~5. Chapter 55 of Title 10, United States Code.~~
- 1024 ~~6. A medical care program of the Indian Health Service or~~
- 1025 ~~of a tribal organization.~~
- 1026 ~~7. The Florida Comprehensive Health Association or another~~
- 1027 ~~state health benefit risk pool.~~
- 1028 ~~8. A health plan offered under chapter 89 of Title 5,~~
- 1029 ~~United States Code.~~
- 1030 ~~9. A public health plan as defined by rule of the~~
- 1031 ~~commission. To the greatest extent possible, such rules must be~~
- 1032 ~~consistent with regulations adopted by the United States~~
- 1033 ~~Department of Health and Human Services.~~
- 1034 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
- 1035 ~~Act (22 U.S.C. s. 2504(e)).~~
- 1036 ~~(b) Creditable coverage does not include coverage that~~
- 1037 ~~consists solely of one or more or any combination thereof of the~~
- 1038 ~~following excepted benefits:~~
- 1039 ~~1. Coverage only for accident, or disability income~~
- 1040 ~~insurance, or any combination thereof.~~
- 1041 ~~2. Coverage issued as a supplement to liability insurance.~~
- 1042 ~~3. Liability insurance, including general liability~~
- 1043 ~~insurance and automobile liability insurance.~~
- 1044 ~~4. Workers' compensation or similar insurance.~~
- 1045 ~~5. Automobile medical payment insurance.~~
- 1046 ~~6. Credit only insurance.~~

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1047 ~~7. Coverage for onsite medical clinics.~~

1048 ~~8. Other similar insurance coverage, specified in rules~~
1049 ~~adopted by the commission, under which benefits for medical care~~
1050 ~~are secondary or incidental to other insurance benefits. To the~~
1051 ~~greatest extent possible, such rules must be consistent with~~
1052 ~~regulations adopted by the United States Department of Health~~
1053 ~~and Human Services.~~

1054 ~~(c) The following benefits are not subject to the~~
1055 ~~creditable coverage requirements, if offered separately;~~

1056 ~~1. Limited scope dental or vision benefits.~~

1057 ~~2. Benefits or long term care, nursing home care, home~~
1058 ~~health care, community-based care, or any combination of these.~~

1059 ~~3. Such other similar, limited benefits as are specified in~~
1060 ~~rules adopted by the commission. To the greatest extent~~
1061 ~~possible, such rules must be consistent with regulations adopted~~
1062 ~~by the United States Department of Health and Human Services.~~

1063 ~~(d) The following benefits are not subject to creditable~~
1064 ~~coverage requirements if offered as independent, noncoordinated~~
1065 ~~benefits:~~

1066 ~~1. Coverage only for a specified disease or illness.~~

1067 ~~2. Hospital indemnity or other fixed indemnity insurance.~~

1068 ~~(e) Benefits provided through Medicare supplemental health~~
1069 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
1070 ~~Act, coverage supplemental to the coverage provided under~~
1071 ~~chapter 55 of Title 10, United States Code, and similar~~
1072 ~~supplemental coverage provided to coverage under a group health~~
1073 ~~plan are not considered creditable coverage if offered as a~~
1074 ~~separate insurance policy.~~

1075 ~~(6) (a) A period of creditable coverage may not be counted,~~

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1076 ~~with respect to enrollment of an individual under a group health~~
1077 ~~maintenance organization contract, if, after such period and~~
1078 ~~before the enrollment date, there was a 63-day period during all~~
1079 ~~of which the individual was not covered under any creditable~~
1080 ~~coverage.~~

1081 ~~(b) Any period during which an individual is in a waiting~~
1082 ~~period, or in an affiliation period as defined in subsection~~
1083 ~~(9), for any coverage under a group health maintenance~~
1084 ~~organization contract may not be taken into account in~~
1085 ~~determining the 63-day period under paragraph (a) or paragraph~~
1086 ~~(4) (b).~~

1087 ~~(7) (a) Except as otherwise provided under paragraph (b), a~~
1088 ~~health maintenance organization shall count a period of~~
1089 ~~creditable coverage without regard to the specific benefits~~
1090 ~~covered under the period.~~

1091 ~~(b) A health maintenance organization may elect to count as~~
1092 ~~creditable coverage, coverage of benefits within each of several~~
1093 ~~classes or categories of benefits specified in rules adopted by~~
1094 ~~the commission rather than as provided under paragraph (a). Such~~
1095 ~~election shall be made on a uniform basis for all participants~~
1096 ~~and beneficiaries. Under such election, a health maintenance~~
1097 ~~organization shall count a period of creditable coverage with~~
1098 ~~respect to any class or category of benefits if any level of~~
1099 ~~benefits is covered within such class or category.~~

1100 ~~(c) In the case of an election with respect to a health~~
1101 ~~maintenance organization under paragraph (b), the organization~~
1102 ~~shall:~~

1103 ~~1. Prominently state in 10-point type or larger in any~~
1104 ~~disclosure statements concerning the contract, and state to each~~

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1105 ~~enrollee at the time of enrollment under the contract, that the~~
1106 ~~organization has made such election; and~~

1107 ~~2. Include in such statements a description of the effect~~
1108 ~~of this election.~~

1109 ~~(8)(a) Periods of creditable coverage with respect to an~~
1110 ~~individual shall be established through presentation of~~
1111 ~~certifications described in this subsection or in such other~~
1112 ~~manner as may be specified in rules adopted by the commission.~~

1113 ~~(b) A health maintenance organization that offers group~~
1114 ~~coverage shall provide the certification described in paragraph~~
1115 ~~(a):~~

1116 ~~1. At the time an individual ceases to be covered under the~~
1117 ~~plan or otherwise becomes covered under a COBRA continuation~~
1118 ~~provision or continuation pursuant to s. 627.6692.~~

1119 ~~2. In the case of an individual becoming covered under a~~
1120 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
1121 ~~time the individual ceases to be covered under such a provision.~~

1122 ~~3. Upon the request on behalf of an individual made not~~
1123 ~~later than 24 months after the date of cessation of the coverage~~
1124 ~~described in this paragraph.~~

1125
1126 ~~The certification under subparagraph 1. may be provided, to the~~
1127 ~~extent practicable, at a time consistent with notices required~~
1128 ~~under any applicable COBRA continuation provision or~~
1129 ~~continuation pursuant to s. 627.6692.~~

1130 ~~(c) The certification is a written certification of:~~

1131 ~~1. The period of creditable coverage of the individual~~
1132 ~~under the contract and the coverage, if any, under such COBRA~~
1133 ~~continuation provision or continuation pursuant to s. 627.6692;~~

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1134 and

1135 ~~2. The waiting period, if any, imposed with respect to the~~
1136 ~~individual for any coverage under such contract.~~

1137 ~~(d) In the case of an election described in subsection (7)~~
1138 ~~by a health maintenance organization, if the organization~~
1139 ~~enrolls an individual for coverage under the plan and the~~
1140 ~~individual provides a certification of coverage of the~~
1141 ~~individual, as provided by this subsection:~~

1142 ~~1. Upon request of such health maintenance organization,~~
1143 ~~the insurer or health maintenance organization that issued the~~
1144 ~~certification provided by the individual shall promptly disclose~~
1145 ~~to such requesting organization information on coverage of~~
1146 ~~classes and categories of health benefits available under such~~
1147 ~~insurer's or health maintenance organization's plan or coverage.~~

1148 ~~2. Such insurer or health maintenance organization may~~
1149 ~~charge the requesting organization for the reasonable cost of~~
1150 ~~disclosing such information.~~

1151 ~~(e) The commission shall adopt rules to prevent an~~
1152 ~~insurer's or health maintenance organization's failure to~~
1153 ~~provide information under this subsection with respect to~~
1154 ~~previous coverage of an individual from adversely affecting any~~
1155 ~~subsequent coverage of the individual under another group health~~
1156 ~~plan or health maintenance organization coverage.~~

1157 ~~(9)(a) A health maintenance organization may provide for an~~
1158 ~~affiliation period with respect to coverage through the~~
1159 ~~organization only if:~~

1160 ~~1. No preexisting condition exclusion is imposed with~~
1161 ~~respect to coverage through the organization;~~

1162 ~~2. The period is applied uniformly without regard to any~~

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1163 ~~health status related factors; and~~

1164 ~~3. Such period does not exceed 2 months or 3 months in the~~
1165 ~~ease of a late enrollee.~~

1166 ~~(b) For the purposes of this section, the term "affiliation~~
1167 ~~period" means a period that, under the terms of the coverage~~
1168 ~~offered by the health maintenance organization, must expire~~
1169 ~~before the coverage becomes effective. The organization is not~~
1170 ~~required to provide health care services or benefits during such~~
1171 ~~period, and no premium may be charged to the participant or~~
1172 ~~beneficiary for any coverage during the period. Such period~~
1173 ~~begins on the enrollment date and runs concurrently with any~~
1174 ~~waiting period under the plan.~~

1175 ~~(c) As an alternative to the method authorized by paragraph~~
1176 ~~(a), a health maintenance organization may address adverse~~
1177 ~~selection in a method approved by the office.~~

1178 ~~(10) (a) Except as provided in paragraph (b), no period~~
1179 ~~before July 1, 1996, shall be taken into account in determining~~
1180 ~~creditable coverage.~~

1181 ~~(b) The commission shall adopt rules that provide a process~~
1182 ~~whereby individuals who need to establish creditable coverage~~
1183 ~~for periods before July 1, 1996, and who would have such~~
1184 ~~coverage credited but for paragraph (a), may be given credit for~~
1185 ~~creditable coverage for such periods through the presentation of~~
1186 ~~documents or other means.~~

1187 ~~(11) Except as otherwise provided in this subsection, the~~
1188 ~~requirements of paragraph (8) (b) shall apply to events that~~
1189 ~~occur on or after July 1, 1996.~~

1190 ~~(a) In no case is a certification required to be provided~~
1191 ~~under paragraph (8) (b) prior to June 1, 1997.~~

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1192 ~~(b) In the case of an event that occurs on or after July 1,~~
1193 ~~1996, and before October 1, 1996, a certification is not~~
1194 ~~required to be provided under paragraph (8) (b), unless an~~
1195 ~~individual, with respect to whom the certification is required~~
1196 ~~to be made, requests such certification in writing.~~

1197 ~~(12) In the case of an individual who seeks to establish~~
1198 ~~creditable coverage for any period for which certification is~~
1199 ~~not required because it relates to an event occurring before~~
1200 ~~July 1, 1996.~~

1201 ~~(a) The individual may present other creditable coverage in~~
1202 ~~order to establish the period of creditable coverage.~~

1203 ~~(b) A health maintenance organization is not subject to any~~
1204 ~~penalty or enforcement action with respect to the organization's~~
1205 ~~crediting, or not crediting, such coverage if the organization~~
1206 ~~has sought to comply in good faith with applicable provisions of~~
1207 ~~this section.~~

1208 ~~(13) For purposes of subsection (10), any plan amendment~~
1209 ~~made pursuant to a collective bargaining agreement relating to~~
1210 ~~the plan which amends the plan solely to conform to any~~
1211 ~~requirement of this section may not be treated as a termination~~
1212 ~~of such collective bargaining agreement.~~

1213 Section 23. Subsections (1), (3), and (4) of section
1214 641.31074, Florida Statutes, are amended to read:

1215 641.31074 Guaranteed renewability of coverage.—

1216 (1) Except as otherwise provided in this section, a health
1217 maintenance organization that issues a ~~group~~ health insurance
1218 contract must renew or continue in force such coverage at the
1219 option of the contract holder.

1220 (3) (a) A health maintenance organization may discontinue

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1221 offering a particular contract form ~~for group coverage offered~~
1222 ~~in the small group market or large group market~~ only if:

1223 1. The health maintenance organization provides notice to
1224 each contract holder provided coverage of this form in such
1225 market, and participants and beneficiaries covered under such
1226 coverage, of such discontinuation at least 90 days prior to the
1227 date of the nonrenewal of such coverage;

1228 2. The health maintenance organization offers to each
1229 contract holder provided coverage of this form in such market
1230 the option to purchase all, or in the case of the large group
1231 market, any other health insurance coverage currently being
1232 offered by the health maintenance organization in such market;
1233 and

1234 3. In exercising the option to discontinue coverage of this
1235 form and in offering the option of coverage under subparagraph
1236 2., the health maintenance organization acts uniformly without
1237 regard to the claims experience of those contract holders or any
1238 health-status-related factor that relates to any participants or
1239 beneficiaries covered or new participants or beneficiaries who
1240 may become eligible for such coverage.

1241 (b)1. In any case in which a health maintenance
1242 organization elects to discontinue offering all coverage in the
1243 individual market, the small group market, ~~or~~ the large group
1244 market, or any combination thereof both, in this state, coverage
1245 may be discontinued by the insurer only if:

1246 a. The health maintenance organization provides notice to
1247 the office and to each contract holder, and participants and
1248 beneficiaries covered under such coverage, of such
1249 discontinuation at least 180 days prior to the date of the

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1250 nonrenewal of such coverage; and

1251 b. All health insurance issued or delivered for issuance in
1252 this state in such market is discontinued and coverage under
1253 such health insurance coverage in such market is not renewed.

1254 2. In the case of a discontinuation under subparagraph 1.
1255 in a market, the health maintenance organization may not provide
1256 for the issuance of any health maintenance organization contract
1257 coverage in the market in this state during the 5-year period
1258 beginning on the date of the discontinuation of the last
1259 insurance contract not renewed.

1260 (4) At the time of coverage renewal, a health maintenance
1261 organization may modify the coverage for a product offered:

1262 (a) In the large group market; ~~or~~

1263 (b) In the small group market if, for coverage that is
1264 available in such market other than only through one or more
1265 bona fide associations, as defined in s. 627.6571(5), such
1266 modification is consistent with s. 627.6699 and effective on a
1267 uniform basis among group health plans with that product; or

1268 (c) In the individual market if the modification is
1269 consistent with the laws of this state and effective on a
1270 uniform basis among all individuals with that policy form.

1271 Section 24. Section 641.312, Florida Statutes, is amended
1272 to read:

1273 641.312 Scope.—The Office of Insurance Regulation may adopt
1274 rules to administer the provisions of the National Association
1275 of Insurance Commissioners' Uniform Health Carrier External
1276 Review Model Act, issued by the National Association of
1277 Insurance Commissioners and dated April 2010. This section does
1278 not apply to a health maintenance contract that is subject to

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1279 the Subscriber Assistance Program under s. 408.7056 or to the
1280 types of benefits or coverages provided under s. 627.6513(1)-
1281 (14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.

1282 Section 25. This act shall take effect July 1, 2016.