COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Cummings offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

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

408.909 Health flex plans.—

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

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis. The terms may also include one or more of the excepted benefits under s. 627.6513(1)-(13)

~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered separately, or the benefits under s. 627.6561(5)(d), if offered as independent, noncoordinated benefits~~.

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

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

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

(2) Be guarantee issued;

(3) Be community rated;

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

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

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

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

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

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

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

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

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

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

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

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

627.411 Grounds for disapproval.—

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

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

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

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

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

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

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

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

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

627.602 Scope, format of policy.—

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

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

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

627.642 Outline of coverage.—

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

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

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

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

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

627.6425 Renewability of individual coverage.—

(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603 ~~627.6561(5)(a)2.~~, offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group

policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection (6) or subsection (7)~~.

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

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

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

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.—

(2) For the purposes of this section:

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

~~contract, the term does not include excepted benefits specified in s. 627.6561(5)(c), (d), or (e)~~.

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

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

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

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

(b) Who is not eligible for coverage under:

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

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or

s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

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

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

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

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

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

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

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

627.6512 Exemption of certain group health insurance policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571

do not apply to~~: (1)~~ any group insurance policy in relation to its provision of ~~excepted~~ benefits described in s. 627.6513(1)-(14) ~~627.6561(5)(b)~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Workers' compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

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

(8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations

adopted by the United States Department of Health and Human Services.

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

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

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

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

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

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

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

627.6561 Preexisting conditions.—

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

(a) "Enrollment date" means, with respect to an individual covered under a group health policy, the date of enrollment of

the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

3. Pregnancy.

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

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

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

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

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

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

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

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

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

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

~~9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be~~

~~consistent with regulations adopted by the United States Department of Health and Human Services.~~

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

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

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

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

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

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

~~5. Automobile medical payment insurance.~~

~~6. Credit-only insurance.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.~~

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

~~1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision or continuation pursuant to s. 627.6692. 2. In the case of an individual becoming covered under a COBRA continuation provision or pursuant to s. 627.6692, at the time the individual ceases to be covered under such a provision.~~

~~3. Upon the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in this paragraph. The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.~~

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

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

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

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

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

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

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

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

~~(b) The commission shall adopt rules that provide a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have~~

~~such coverage credited but for paragraph (a), may be given credit for creditable coverage for such periods through the presentation of documents or other means. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.~~

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

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

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

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

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

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

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

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

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

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

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

627.6562 Dependent coverage.—

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

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

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

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

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

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

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

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

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

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

9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be

consistent with regulations adopted by the United States Department of Health and Human Services.

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

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

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

2. Coverage issued as a supplement to liability insurance.

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

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

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

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

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

1. Limited scope dental or vision benefits.

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

3. Other similar, limited benefits specified in rules adopted by the commission.

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

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

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

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

627.65626 Insurance rebates for healthy lifestyles.—

(1) Any rate, rating schedule, or rating manual for a health insurance policy that provides creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan have enrolled and

maintained participation in any health wellness, maintenance, orimprovement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the last calendar year or policy year. The group must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the policyholder and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. The group or health insurer may contract with a third-party administrator to assemble and report the health status required in this subsection between the policyholder and the health insurer. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceed the value of the rebate, but the rebate may not exceed 10 percent of paid premiums.

Section 17. Paragraphs (e), (l), and (n) of subsection (3), paragraph (d) of subsection (5), and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

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

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

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

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

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

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows adjustments for~~:~~ claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

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

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

~~2. Paragraph (c) applies to health benefit plans issued to a small employer who has two or more eligible employees and to~~

~~health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.~~

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

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is determined solely on the basis of the eligible employee's and

eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(e) ~~(5)(f)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with

rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of

the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10

employees. For the purposes of this subparagraph, the term "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees

for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

Section 18. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

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

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

2. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in

Medicare Part B, and who resides in this state, upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.

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

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

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

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

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

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

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

Section 19. Subsection (2) and paragraph (a) of subsection (40) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. ~~A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons.~~ The commission, inimprovement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the

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

Section 17. Paragraphs (e), (l), and (n) of subsection (3), paragraph (d) of subsection (5), and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

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

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

(l) "Late enrollee" means an eligible employee or dependent who, with respect to coverage under a group health

policy, is a participant or beneficiary who enrolls under the policy other than during:

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

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

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows adjustments for~~:~~ claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

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

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

~~2. Paragraph (c) applies to health benefit plans issued to a small employer who has two or more eligible employees and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who~~

~~has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.~~

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

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(e)

~~(5)(f)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the

alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment

exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term "composite rating methodology" means a rating methodology that

averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

Section 18. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

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

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

2. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in Medicare Part B, and who resides in this state, upon the request

of the individual during the 2-month period following termination of coverage under a group health insurance policy.

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

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

(d) As a part of an insurer's rate filings, before and including the insurer's first rate filing for a block of policy forms in 2015, notwithstanding the provisions of s. 627.410(6)(e)3., an insurer shall consider the experience of the policies or certificates for the premium classes including individuals under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease separately from the balance of the block so as not to affect the other premium classes. For filings in such time period only, credibility of that experience shall be as follows: if a block of policy forms has 1,250 or more policies or certificates in force in the age

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

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

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

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

Section 19. Subsection (2) and paragraph (a) of subsection (40) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. ~~A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons.~~ The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what

constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

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

Section 20. Section 651.31071, Florida Statutes, is amended to read:

641.31071 Preexisting conditions.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~5. Automobile medical payment insurance.~~

~~6. Credit-only insurance.~~

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

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

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

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

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

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

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

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

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

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

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

~~of which the individual was not covered under any creditable coverage.~~

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

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

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

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

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

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

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

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

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

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

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

~~The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required~~

~~under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.~~

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

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

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

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

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

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

~~(e) The commission shall adopt rules to prevent an insurer's or health maintenance organization's failure to provide information under this subsection with respect to~~

~~previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health maintenance organization coverage.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

641.31074 Guaranteed renewability of coverage.—

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

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

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

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

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

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

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

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

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

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

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

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

(c) In the individual market so long as such modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.

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

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, issued by the National Association of

Insurance Commissioners and dated April 2010. This section does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6513(1)-(14) ~~627.6561(5)(b)-(c)~~ issued in any market.

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

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

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 ss. 627.6011 and 627.602, incurred claims; amending ss. 627.6011 and 627.602, F.S.; conforming cross-references; 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. 627.6513, F.S.; excluding applicability as to certain types of benefits or coverages; amending s. 627.6561, F.S.; revising conditions under which an insurer may impose a preexisting condition exclusion; deleting the definition of the term "creditable coverage"; removing application and reporting requirements relating to creditable coverage to conform to changes made by the act; amending s. 627.6562, F.S.; redefining the term "creditable coverage"; providing exceptions andapplicability; amending s. 627.65626, F.S.; conforming a cross-reference; amending s. 627.6699, F.S.; redefining terms; deleting a provision that requires a certain health benefit plan to comply with specified preexisting condition provisions; conforming provisions to changes made by the act; amending s. 627.6741, F.S.; conforming cross-references; conforming a provision to changes made by the act; amending s. 641.31, F.S.; deleting a provision specifying that a law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments may not apply to a certain health maintenance organization contract; conforming a cross-reference; amending s. 641.31071, F.S.;

conforming a cross-reference; amending s. 641.31074, F.S.; revising provisions relating to guaranteed renewability of coverage; amending s. 641.312, F.S.; conforming a cross-reference; providing an effective date.