

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	<u> </u>	(Y/N)
ADOPTED AS AMENDED	<u> </u>	(Y/N)
ADOPTED W/O OBJECTION	<u> </u>	(Y/N)
FAILED TO ADOPT	<u> </u>	(Y/N)
WITHDRAWN	<u> </u>	(Y/N)
OTHER	<u> </u>	

1 Committee/Subcommittee hearing bill: Insurance & Banking
 2 Subcommittee
 3 Representative Cummings offered the following:

Amendment (with title amendment)

6 Remove everything after the enacting clause and insert:
 7 Section 1. Paragraph (d) of subsection (2) of section 408.909,
 8 Florida Statutes, is amended to read:

9 408.909 Health flex plans.—

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

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

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18 ~~627.6561(5) (b), the benefits under s. 627.6561(5) (c), if offered~~
19 ~~separately, or the benefits under s. 627.6561(5) (d), if offered~~
20 ~~as independent, noncoordinated benefits.~~

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

23 409.817 Approval of health benefits coverage; financial
24 assistance.—In order for health insurance coverage to qualify
25 for premium assistance payments for an eligible child under ss.
26 409.810-409.821, the health benefits coverage must:

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

31 (2) Be guarantee issued;

32 (3) Be community rated;

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

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

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

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

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43 Section 3. Paragraph (b) of subsection (1) of section
44 624.123, Florida Statutes, is amended to read:

45 624.123 Certain international health insurance policies;
46 exemption from code.—

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

53 (b) "International health insurance policy" means health
54 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2.

55 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
56 only a resident of a foreign country on an annual basis.

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

59 627.402 Definitions.—As used in this part, the term:

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

64 ~~(e).~~

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

67 627.411 Grounds for disapproval.—

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68 ~~(3)(a) For health insurance coverage as described in s.~~
69 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
70 ~~claims to earned premium for the form shall be 65 percent.~~

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

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

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

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

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

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

95 627.6011 Mandated coverages.—Mandatory health benefits
96 regulated under this chapter are not intended to apply to the
97 types of health benefit plans listed in s. 627.6513(1)-(14)
98 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically
99 designated otherwise. For purposes of this section, the term
100 "mandatory health benefits" means those benefits set forth in
101 ss. 627.6401-627.64193, and any other mandatory treatment or
102 health coverages or benefits enacted on or after July 1, 2012.

103 Section 7. Paragraph (h) of subsection (1) of section
104 627.602, Florida Statutes, is amended to read:

105 627.602 Scope, format of policy.—

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

110 (h) Section 641.312 and the provisions of the Employee
111 Retirement Income Security Act of 1974, as implemented by 29
112 C.F.R. s. 2560.503-1, relating to internal grievances. This
113 paragraph does not apply to a health insurance policy that is
114 subject to the Subscriber Assistance Program under s. 408.7056
115 or to the types of benefits or coverages provided under s.
116 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.

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

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119 627.642 Outline of coverage.—

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

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

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

130
131 In the case of a direct response, such as a written application
132 to the insurance company from an applicant, the outline of
133 coverage shall accompany the policy when issued.

134 Section 9. Subsections (1), (6), and (7) of section
135 627.6425, Florida Statutes, are amended to read:

136 627.6425 Renewability of individual coverage.—

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

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

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

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

157 Section 10. Paragraph (b) of subsection (2) and subsection
158 (3) of section 627.6487, Florida Statutes, are amended to read:
159 627.6487 Guaranteed availability of individual health
160 insurance coverage to eligible individuals.-

161 (2) For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

210 (d) Who, having been offered the option of continuation
211 coverage under a COBRA continuation provision or under s.
212 627.6692, elected such coverage; and

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

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

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

220 627.6512 Exemption of certain group health insurance
221 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571

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222 do not apply to: ~~(1) any group insurance policy in relation to~~
223 ~~its provision of excepted benefits described in s. 627.6513(1)-~~
224 ~~(14) 627.6561(5)(b).~~

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

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

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

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

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

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

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

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

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

249 627.6513 Scope.—Section 641.312 and the provisions of the
250 Employee Retirement Income Security Act of 1974, as implemented
251 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
252 apply to all group health insurance policies issued under this
253 part. This section does not apply to a group health insurance
254 policy that is subject to the Subscriber Assistance Program in
255 s. 408.7056 or to ~~the types of benefits or coverages provided~~
256 ~~under s. 627.6561(5)(b)-(e) issued in any market.:~~

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

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

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

263 (4) Workers' compensation or similar insurance.

264 (5) Automobile medical payment insurance.

265 (6) Credit-only insurance.

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

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

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

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

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

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

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

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

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

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

294 627.6561 Preexisting conditions.—

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

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

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

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

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

305 2. A special enrollment period, as provided under s.
306 627.65615.

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

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

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

321 (b) Such exclusion extends for a period of not more than
322 12 months, or 18 months in the case of a late enrollee, after
323 the enrollment date; and

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

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

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

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

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

344 3. Pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

386 ~~5. Automobile medical payment insurance.~~

387 ~~6. Credit only insurance.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

507 ~~(10) Except as otherwise provided in this subsection,~~
508 ~~paragraph (8) (b) applies to events that occur on or after July~~
509 ~~1, 1996.~~

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

512 ~~(b) In the case of an event that occurred on or after July~~
513 ~~1, 1996, and before October 1, 1996, a certification is not~~
514 ~~required to be provided under paragraph (8) (b), unless an~~
515 ~~individual, with respect to whom the certification is required~~
516 ~~to be made, requests such certification in writing.~~

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

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

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

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

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

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

540 ~~(15) This section applies to health insurance coverage~~
541 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
542 ~~1997.~~

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

545 627.6562 Dependent coverage.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

590 4. Workers' compensation or similar insurance.

591 5. Automobile medical payment insurance.

592 6. Credit-only insurance.

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

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

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

603 1. Limited scope dental or vision benefits.

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

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

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

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

613 2. Hospital indemnity or other fixed indemnity insurance.

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

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

623 627.65626 Insurance rebates for healthy lifestyles.—

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

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

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

652 627.6699 Employee Health Care Access Act.—

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

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

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

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

662 2. A special enrollment period, as provided under s.
663 627.65615 as defined under s. 627.6561(1)(b).

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

673 (5) AVAILABILITY OF COVERAGE.—

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

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

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

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682 ~~health benefit plans that are issued to a small employer who has~~
683 ~~fewer than two eligible employees and that cover an employee who~~
684 ~~has had creditable coverage continually to a date not more than~~
685 ~~63 days before the effective date of the new coverage.~~

686 2.3. For health benefit plans that are issued to a small
687 employer who has fewer than two employees and that cover an
688 employee who has not been continually covered by creditable
689 coverage within 63 days before the effective date of the new
690 coverage, preexisting condition provisions must not exclude
691 coverage for a period beyond 24 months following the employee's
692 effective date of coverage and may relate only to:

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

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

700 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

818 627.6741 Issuance, cancellation, nonrenewal, and
819 replacement.—

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

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

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

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

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

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

853 (d) As a part of an insurer's rate filings, before and
854 including the insurer's first rate filing for a block of policy
855 forms in 2015, notwithstanding the provisions of s.
856 627.410(6)(e)3., an insurer shall consider the experience of the
857 policies or certificates for the premium classes including
858 individuals under 65 years of age and eligible for Medicare by
859 reason of disability or end-stage renal disease separately from
860 the balance of the block so as not to affect the other premium
861 classes. For filings in such time period only, credibility of
862 that experience shall be as follows: if a block of policy forms

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863 has 1,250 or more policies or certificates in force in the age
864 band including ages under 65 years of age, full or 100-percent
865 credibility shall be given to the experience; and if fewer than
866 250 policies or certificates are in force, no or zero-percent
867 credibility shall be given. Linear interpolation shall be used
868 for in-force amounts between the low and high values. Florida-
869 only experience shall be used if it is 100-percent credible. If
870 Florida-only experience is not 100-percent credible, a
871 combination of Florida-only and nationwide experience shall be
872 used. If Florida-only experience is zero-percent credible,
873 nationwide experience shall be used. The insurer may file its
874 initial rates and any rate adjustment based upon the experience
875 of these policies or certificates or based upon expected claim
876 experience using experience data of the same company, other
877 companies in the same or other states, or using data publicly
878 available from the Centers for Medicaid and Medicare Services if
879 the insurer's combined Florida and nationwide experience is not
880 100-percent credible, separate from the balance of all other
881 Medicare supplement policies.

882

883 A Medicare supplement policy issued to an individual under
884 subparagraph (a)1. or subparagraph (a)2. may not exclude
885 benefits based on a preexisting condition if the individual has
886 a continuous period of creditable coverage, as defined in s.
887 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
888 application for coverage.

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

891 (c) If a Medicare supplement policy or certificate
892 replaces another Medicare supplement policy or certificate or
893 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
894 the replacing insurer shall waive any time periods applicable to
895 preexisting conditions, waiting periods, elimination periods,
896 and probationary periods in the new Medicare supplement policy
897 for similar benefits to the extent such time was spent under the
898 original policy, ~~subject to the requirements of s. 627.6561(6)~~
899 ~~(11)~~.

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

902 641.31 Health maintenance contracts.—

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

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

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

934 627.6699 Employee Health Care Access Act.—

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

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

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

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

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

944 2. A special enrollment period, as provided under s.
945 627.65615 as defined under s. 627.6561(1)(b).

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

955 (5) AVAILABILITY OF COVERAGE.—

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

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

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

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966 ~~has had creditable coverage continually to a date not more than~~
967 ~~63 days before the effective date of the new coverage.~~

968 ~~2.3.~~ For health benefit plans that are issued to a small
969 employer who has fewer than two employees and that cover an
970 employee who has not been continually covered by creditable
971 coverage within 63 days before the effective date of the new
972 coverage, preexisting condition provisions must not exclude
973 coverage for a period beyond 24 months following the employee's
974 effective date of coverage and may relate only to:

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

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

982 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

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

1000 3. Small employer carriers may not modify the rate for a
1001 small employer for 12 months from the initial issue date or
1002 renewal date, unless the composition of the group changes or
1003 benefits are changed. However, a small employer carrier may
1004 modify the rate one time within the 12 months after the initial
1005 issue date for a small employer who enrolls under a previously
1006 issued group policy that has a common anniversary date for all
1007 employers covered under the policy if:

1008 a. The carrier discloses to the employer in a clear and
1009 conspicuous manner the date of the first renewal and the fact
1010 that the premium may increase on or after that date.

1011 b. The insurer demonstrates to the office that
1012 efficiencies in administration are achieved and reflected in the
1013 rates charged to small employers covered under the policy.

1014 4. A carrier may issue a group health insurance policy to
1015 a small employer health alliance or other group association with
1016 rates that reflect a premium credit for expense savings
1017 attributable to administrative activities being performed by the

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1018 alliance or group association if such expense savings are
1019 specifically documented in the insurer's rate filing and are
1020 approved by the office. Any such credit may not be based on
1021 different morbidity assumptions or on any other factor related
1022 to the health status or claims experience of any person covered
1023 under the policy. This subparagraph does not exempt an alliance
1024 or group association from licensure for activities that require
1025 licensure under the insurance code. A carrier issuing a group
1026 health insurance policy to a small employer health alliance or
1027 other group association shall allow any properly licensed and
1028 appointed agent of that carrier to market and sell the small
1029 employer health alliance or other group association policy. Such
1030 agent shall be paid the usual and customary commission paid to
1031 any agent selling the policy.

1032 5. Any adjustments in rates for claims experience, health
1033 status, or duration of coverage may not be charged to individual
1034 employees or dependents. For a small employer's policy, such
1035 adjustments may not result in a rate for the small employer
1036 which deviates more than 15 percent from the carrier's approved
1037 rate. Any such adjustment must be applied uniformly to the rates
1038 charged for all employees and dependents of the small employer.
1039 A small employer carrier may make an adjustment to a small
1040 employer's renewal premium, up to 10 percent annually, due to
1041 the claims experience, health status, or duration of coverage of
1042 the employees or dependents of the small employer. If the
1043 aggregate resulting from the application of such adjustment

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1044 exceeds the premium that would have been charged by application
1045 of the approved modified community rate by 4 percent for the
1046 current policy term, the carrier shall limit the application of
1047 such adjustments only to minus adjustments. For any subsequent
1048 policy term, if the total aggregate adjusted premium actually
1049 charged does not exceed the premium that would have been charged
1050 by application of the approved modified community rate by 4
1051 percent, the carrier may apply both plus and minus adjustments.
1052 A small employer carrier may provide a credit to a small
1053 employer's premium based on administrative and acquisition
1054 expense differences resulting from the size of the group. Group
1055 size administrative and acquisition expense factors may be
1056 developed by each carrier to reflect the carrier's experience
1057 and are subject to office review and approval.

1058 6. A small employer carrier rating methodology may include
1059 separate rating categories for one dependent child, for two
1060 dependent children, and for three or more dependent children for
1061 family coverage of employees having a spouse and dependent
1062 children or employees having dependent children only. A small
1063 employer carrier may have fewer, but not greater, numbers of
1064 categories for dependent children than those specified in this
1065 subparagraph.

1066 7. Small employer carriers may not use a composite rating
1067 methodology to rate a small employer with fewer than 10
1068 employees. For the purposes of this subparagraph, the term
1069 "composite rating methodology" means a rating methodology that

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1070 averages the impact of the rating factors for age and gender in
1071 the premiums charged to all of the employees of a small
1072 employer.

1073 8. A carrier may separate the experience of small employer
1074 groups with fewer than 2 eligible employees from the experience
1075 of small employer groups with 2-50 eligible employees for
1076 purposes of determining an alternative modified community
1077 rating.

1078 a. If a carrier separates the experience of small employer
1079 groups, the rate to be charged to small employer groups of fewer
1080 than 2 eligible employees may not exceed 150 percent of the rate
1081 determined for small employer groups of 2-50 eligible employees.
1082 However, the carrier may charge excess losses of the experience
1083 pool consisting of small employer groups with less than 2
1084 eligible employees to the experience pool consisting of small
1085 employer groups with 2-50 eligible employees so that all losses
1086 are allocated and the 150-percent rate limit on the experience
1087 pool consisting of small employer groups with less than 2
1088 eligible employees is maintained.

1089 b. Notwithstanding s. 627.411(1), the rate to be charged
1090 to a small employer group of fewer than 2 eligible employees,
1091 insured as of July 1, 2002, may be up to 125 percent of the rate
1092 determined for small employer groups of 2-50 eligible employees
1093 for the first annual renewal and 150 percent for subsequent
1094 annual renewals.

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1095 9. A carrier shall separate the experience of
1096 grandfathered health plans from nongrandfathered health plans
1097 for determining rates.

1098 Section 18. Subsection (1) and paragraph (c) of subsection
1099 (2) of section 627.6741, Florida Statutes, are amended to read:

1100 627.6741 Issuance, cancellation, nonrenewal, and
1101 replacement.—

1102 (1)(a) An insurer issuing Medicare supplement policies in
1103 this state shall offer the opportunity of enrolling in a
1104 Medicare supplement policy, without conditioning the issuance or
1105 effectiveness of the policy on, and without discriminating in
1106 the price of the policy based on, the medical or health status
1107 or receipt of health care by the individual:

1108 1. To any individual who is 65 years of age or older, or
1109 under 65 years of age and eligible for Medicare by reason of
1110 disability or end-stage renal disease, and who resides in this
1111 state, upon the request of the individual during the 6-month
1112 period beginning with the first month in which the individual
1113 has attained 65 years of age and is enrolled in Medicare Part B,
1114 or is eligible for Medicare by reason of a disability or end-
1115 stage renal disease, and is enrolled in Medicare Part B; or

1116 2. To any individual who is 65 years of age or older, or
1117 under 65 years of age and eligible for Medicare by reason of a
1118 disability or end-stage renal disease, who is enrolled in
1119 Medicare Part B, and who resides in this state, upon the request

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1120 of the individual during the 2-month period following
1121 termination of coverage under a group health insurance policy.

1122 (b) The 6-month period to enroll in a Medicare supplement
1123 policy for an individual who is under 65 years of age and is
1124 eligible for Medicare by reason of disability or end-stage renal
1125 disease and otherwise eligible under subparagraph (a)1. or
1126 subparagraph (a)2. and first enrolled in Medicare Part B before
1127 October 1, 2009, begins on October 1, 2009.

1128 (c) A company that has offered Medicare supplement
1129 policies to individuals under 65 years of age who are eligible
1130 for Medicare by reason of disability or end-stage renal disease
1131 before October 1, 2009, may, for one time only, effect a rate
1132 schedule change that redefines the age bands of the premium
1133 classes without activating the period of discontinuance required
1134 by s. 627.410(6)(e)2.

1135 (d) As a part of an insurer's rate filings, before and
1136 including the insurer's first rate filing for a block of policy
1137 forms in 2015, notwithstanding the provisions of s.
1138 627.410(6)(e)3., an insurer shall consider the experience of the
1139 policies or certificates for the premium classes including
1140 individuals under 65 years of age and eligible for Medicare by
1141 reason of disability or end-stage renal disease separately from
1142 the balance of the block so as not to affect the other premium
1143 classes. For filings in such time period only, credibility of
1144 that experience shall be as follows: if a block of policy forms
1145 has 1,250 or more policies or certificates in force in the age

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1146 band including ages under 65 years of age, full or 100-percent
1147 credibility shall be given to the experience; and if fewer than
1148 250 policies or certificates are in force, no or zero-percent
1149 credibility shall be given. Linear interpolation shall be used
1150 for in-force amounts between the low and high values. Florida-
1151 only experience shall be used if it is 100-percent credible. If
1152 Florida-only experience is not 100-percent credible, a
1153 combination of Florida-only and nationwide experience shall be
1154 used. If Florida-only experience is zero-percent credible,
1155 nationwide experience shall be used. The insurer may file its
1156 initial rates and any rate adjustment based upon the experience
1157 of these policies or certificates or based upon expected claim
1158 experience using experience data of the same company, other
1159 companies in the same or other states, or using data publicly
1160 available from the Centers for Medicaid and Medicare Services if
1161 the insurer's combined Florida and nationwide experience is not
1162 100-percent credible, separate from the balance of all other
1163 Medicare supplement policies.

1164
1165 A Medicare supplement policy issued to an individual under
1166 subparagraph (a)1. or subparagraph (a)2. may not exclude
1167 benefits based on a preexisting condition if the individual has
1168 a continuous period of creditable coverage, as defined in s.
1169 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
1170 application for coverage.

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1171 (2) For both individual and group Medicare supplement
1172 policies:

1173 (c) If a Medicare supplement policy or certificate
1174 replaces another Medicare supplement policy or certificate or
1175 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
1176 the replacing insurer shall waive any time periods applicable to
1177 preexisting conditions, waiting periods, elimination periods,
1178 and probationary periods in the new Medicare supplement policy
1179 for similar benefits to the extent such time was spent under the
1180 original policy, ~~subject to the requirements of s. 627.6561(6)~~
1181 ~~(11)~~.

1182 Section 19. Subsection (2) and paragraph (a) of subsection
1183 (40) of section 641.31, Florida Statutes, are amended to read:

1184 641.31 Health maintenance contracts.—

1185 (2) The rates charged by any health maintenance
1186 organization to its subscribers shall not be excessive,
1187 inadequate, or unfairly discriminatory or follow a rating
1188 methodology that is inconsistent, indeterminate, or ambiguous or
1189 encourages misrepresentation or misunderstanding. ~~A law~~
1190 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
1191 ~~annual or lifetime maximum payments shall not apply to any~~
1192 ~~health maintenance organization contract that provides coverage~~
1193 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
1194 ~~individual or a group of 51 or more persons.~~ The commission, in
1195 accordance with generally accepted actuarial practice as applied
1196 to health maintenance organizations, may define by rule what

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1197 constitutes excessive, inadequate, or unfairly discriminatory
1198 rates and may require whatever information it deems necessary to
1199 determine that a rate or proposed rate meets the requirements of
1200 this subsection.

1201 (40)(a) Any group rate, rating schedule, or rating manual
1202 for a health maintenance organization policy, which provides
1203 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
1204 filed with the office shall provide for an appropriate rebate of
1205 premiums paid in the last policy year, contract year, or
1206 calendar year when the majority of members of a health plan are
1207 enrolled in and have maintained participation in any health
1208 wellness, maintenance, or improvement program offered by the
1209 group contract holder. The group must provide evidence of
1210 demonstrative maintenance or improvement of his or her health
1211 status as determined by assessments of agreed-upon health status
1212 indicators between the group and the health insurer, including,
1213 but not limited to, reduction in weight, body mass index, and
1214 smoking cessation. Any rebate provided by the health maintenance
1215 organization is presumed to be appropriate unless credible data
1216 demonstrates otherwise, or unless the rebate program requires
1217 the insured to incur costs to qualify for the rebate which
1218 equals or exceeds the value of the rebate but the rebate may not
1219 exceed 10 percent of paid premiums.

1220 Section 20. Section 651.31071, Florida Statutes, is
1221 amended to read:

1222 641.31071 Preexisting conditions.—

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1223 (1) As used in this section, the term:

1224 (a) "Enrollment date" means, with respect to an individual
1225 covered under a group health maintenance organization contract,
1226 the date of enrollment of the individual in the plan or coverage
1227 or, if earlier, the first day of the waiting period of such
1228 enrollment.

1229 (b) "Late enrollee" means, with respect to coverage under
1230 a group health maintenance organization contract, a participant
1231 or beneficiary who enrolls under the contract other than during:

1232 1. The first period in which the individual is eligible to
1233 enroll under the plan.

1234 2. A special enrollment period, as provided under s.
1235 641.31072.

1236 (c) "Waiting period" means, with respect to a group health
1237 maintenance organization contract and an individual who is a
1238 potential participant or beneficiary under the contract, the
1239 period that must pass with respect to the individual before the
1240 individual is eligible to be covered for benefits under the
1241 terms of the contract.

1242 (2) Subject to the exceptions specified in subsection (4),
1243 a health maintenance organization that offers group coverage,
1244 may, with respect to a participant or beneficiary, impose a
1245 preexisting condition exclusion only if:

1246 (a) Such exclusion relates to a physical or mental
1247 condition, regardless of the cause of the condition, for which
1248 medical advice, diagnosis, care, or treatment was recommended or

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1249 received within the 6-month period ending on the enrollment
1250 date;

1251 (b) Such exclusion extends for a period of not more than
1252 12 months, or 18 months in the case of a late enrollee, after
1253 the enrollment date; and

1254 (c) The period of any such preexisting condition exclusion
1255 is reduced by the aggregate of the periods of creditable
1256 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
1257 applicable to the participant or beneficiary as of the
1258 enrollment date.

1259 (3) Genetic information shall not be treated as a
1260 condition described in paragraph (2)(a) in the absence of a
1261 diagnosis of the condition related to such information.

1262 (4)(a) Subject to paragraph (b), a health maintenance
1263 organization that offers group coverage may not impose any
1264 preexisting condition exclusion in the case of:

1265 1. An individual who, as of the last day of the 30-day
1266 period beginning with the date of birth, is covered under
1267 creditable coverage.

1268 2. A child who is adopted or placed for adoption before
1269 attaining 18 years of age and who, as of the last day of the 30-
1270 day period beginning on the date of the adoption or placement
1271 for adoption, is covered under creditable coverage. This
1272 provision shall not apply to coverage before the date of such
1273 adoption or placement for adoption.

1274 3. Pregnancy.

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1275 (b) Subparagraphs (a)1. and 2. do not apply to an
1276 individual after the end of the first 63-day period during all
1277 of which the individual was not covered under any creditable
1278 coverage.

1279 ~~(5) (a) The term "creditable coverage" means, with respect~~
1280 ~~to an individual, coverage of the individual under any of the~~
1281 ~~following:~~

1282 ~~1. A group health plan, as defined in s. 2791 of the~~
1283 ~~Public Health Service Act.~~

1284 ~~2. Health insurance coverage consisting of medical care,~~
1285 ~~provided directly, through insurance or reimbursement or~~
1286 ~~otherwise, and including terms and services paid for as medical~~
1287 ~~care, under any hospital or medical service policy or~~
1288 ~~certificate, hospital or medical service plan contract, or~~
1289 ~~health maintenance contract offered by a health insurance~~
1290 ~~issuer.~~

1291 ~~3. Part A or part B of Title XVIII of the Social Security~~
1292 ~~Act.~~

1293 ~~4. Title XIX of the Social Security Act, other than~~
1294 ~~coverage consisting solely of benefits under s. 1928.~~

1295 ~~5. Chapter 55 of Title 10, United States Code.~~

1296 ~~6. A medical care program of the Indian Health Service or~~
1297 ~~of a tribal organization.~~

1298 ~~7. The Florida Comprehensive Health Association or another~~
1299 ~~state health benefit risk pool.~~

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1300 ~~8. A health plan offered under chapter 89 of Title 5,~~
1301 ~~United States Code.~~

1302 ~~9. A public health plan as defined by rule of the~~
1303 ~~commission. To the greatest extent possible, such rules must be~~
1304 ~~consistent with regulations adopted by the United States~~
1305 ~~Department of Health and Human Services.~~

1306 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
1307 ~~Act (22 U.S.C. s. 2504(e)).~~

1308 ~~(b) Creditable coverage does not include coverage that~~
1309 ~~consists solely of one or more or any combination thereof of the~~
1310 ~~following excepted benefits:~~

1311 ~~1. Coverage only for accident, or disability income~~
1312 ~~insurance, or any combination thereof.~~

1313 ~~2. Coverage issued as a supplement to liability insurance.~~

1314 ~~3. Liability insurance, including general liability~~
1315 ~~insurance and automobile liability insurance.~~

1316 ~~4. Workers' compensation or similar insurance.~~

1317 ~~5. Automobile medical payment insurance.~~

1318 ~~6. Credit only insurance.~~

1319 ~~7. Coverage for onsite medical clinics.~~

1320 ~~8. Other similar insurance coverage, specified in rules~~
1321 ~~adopted by the commission, under which benefits for medical care~~
1322 ~~are secondary or incidental to other insurance benefits. To the~~
1323 ~~greatest extent possible, such rules must be consistent with~~
1324 ~~regulations adopted by the United States Department of Health~~
1325 ~~and Human Services.~~

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1326 ~~(c) The following benefits are not subject to the~~
1327 ~~creditable coverage requirements, if offered separately;~~

1328 ~~1. Limited scope dental or vision benefits.~~

1329 ~~2. Benefits or long term care, nursing home care, home~~
1330 ~~health care, community-based care, or any combination of these.~~

1331 ~~3. Such other similar, limited benefits as are specified~~
1332 ~~in rules adopted by the commission. To the greatest extent~~
1333 ~~possible, such rules must be consistent with regulations adopted~~
1334 ~~by the United States Department of Health and Human Services.~~

1335 ~~(d) The following benefits are not subject to creditable~~
1336 ~~coverage requirements if offered as independent, noncoordinated~~
1337 ~~benefits:~~

1338 ~~1. Coverage only for a specified disease or illness.~~

1339 ~~2. Hospital indemnity or other fixed indemnity insurance.~~

1340 ~~(e) Benefits provided through Medicare supplemental health~~
1341 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
1342 ~~Act, coverage supplemental to the coverage provided under~~
1343 ~~chapter 55 of Title 10, United States Code, and similar~~
1344 ~~supplemental coverage provided to coverage under a group health~~
1345 ~~plan are not considered creditable coverage if offered as a~~
1346 ~~separate insurance policy.~~

1347 ~~(6) (a) A period of creditable coverage may not be counted,~~
1348 ~~with respect to enrollment of an individual under a group health~~
1349 ~~maintenance organization contract, if, after such period and~~
1350 ~~before the enrollment date, there was a 63-day period during all~~

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1351 ~~of which the individual was not covered under any creditable~~
1352 ~~coverage.~~

1353 ~~(b) Any period during which an individual is in a waiting~~
1354 ~~period, or in an affiliation period as defined in subsection~~
1355 ~~(9), for any coverage under a group health maintenance~~
1356 ~~organization contract may not be taken into account in~~
1357 ~~determining the 63-day period under paragraph (a) or paragraph~~
1358 ~~(4)(b).~~

1359 ~~(7)(a) Except as otherwise provided under paragraph (b), a~~
1360 ~~health maintenance organization shall count a period of~~
1361 ~~creditable coverage without regard to the specific benefits~~
1362 ~~covered under the period.~~

1363 ~~(b) A health maintenance organization may elect to count~~
1364 ~~as creditable coverage, coverage of benefits within each of~~
1365 ~~several classes or categories of benefits specified in rules~~
1366 ~~adopted by the commission rather than as provided under~~
1367 ~~paragraph (a). Such election shall be made on a uniform basis~~
1368 ~~for all participants and beneficiaries. Under such election, a~~
1369 ~~health maintenance organization shall count a period of~~
1370 ~~creditable coverage with respect to any class or category of~~
1371 ~~benefits if any level of benefits is covered within such class~~
1372 ~~or category.~~

1373 ~~(c) In the case of an election with respect to a health~~
1374 ~~maintenance organization under paragraph (b), the organization~~
1375 ~~shall:~~

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1376 ~~1. Prominently state in 10-point type or larger in any~~
1377 ~~disclosure statements concerning the contract, and state to each~~
1378 ~~enrollee at the time of enrollment under the contract, that the~~
1379 ~~organization has made such election; and~~

1380 ~~2. Include in such statements a description of the effect~~
1381 ~~of this election.~~

1382 ~~(8) (a) Periods of creditable coverage with respect to an~~
1383 ~~individual shall be established through presentation of~~
1384 ~~certifications described in this subsection or in such other~~
1385 ~~manner as may be specified in rules adopted by the commission.~~

1386 ~~(b) A health maintenance organization that offers group~~
1387 ~~coverage shall provide the certification described in paragraph~~
1388 ~~(a):~~

1389 ~~1. At the time an individual ceases to be covered under~~
1390 ~~the plan or otherwise becomes covered under a COBRA continuation~~
1391 ~~provision or continuation pursuant to s. 627.6692.~~

1392 ~~2. In the case of an individual becoming covered under a~~
1393 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
1394 ~~time the individual ceases to be covered under such a provision.~~

1395 ~~3. Upon the request on behalf of an individual made not~~
1396 ~~later than 24 months after the date of cessation of the coverage~~
1397 ~~described in this paragraph.~~

1398
1399 ~~The certification under subparagraph 1. may be provided, to the~~
1400 ~~extent practicable, at a time consistent with notices required~~

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1401 ~~under any applicable COBRA continuation provision or~~
1402 ~~continuation pursuant to s. 627.6692.~~

1403 ~~(c) The certification is a written certification of:~~

1404 ~~1. The period of creditable coverage of the individual~~
1405 ~~under the contract and the coverage, if any, under such COBRA~~
1406 ~~continuation provision or continuation pursuant to s. 627.6692;~~
1407 ~~and~~

1408 ~~2. The waiting period, if any, imposed with respect to the~~
1409 ~~individual for any coverage under such contract.~~

1410 ~~(d) In the case of an election described in subsection (7)~~
1411 ~~by a health maintenance organization, if the organization~~
1412 ~~enrolls an individual for coverage under the plan and the~~
1413 ~~individual provides a certification of coverage of the~~
1414 ~~individual, as provided by this subsection:~~

1415 ~~1. Upon request of such health maintenance organization,~~
1416 ~~the insurer or health maintenance organization that issued the~~
1417 ~~certification provided by the individual shall promptly disclose~~
1418 ~~to such requesting organization information on coverage of~~
1419 ~~classes and categories of health benefits available under such~~
1420 ~~insurer's or health maintenance organization's plan or coverage.~~

1421 ~~2. Such insurer or health maintenance organization may~~
1422 ~~charge the requesting organization for the reasonable cost of~~
1423 ~~disclosing such information.~~

1424 ~~(e) The commission shall adopt rules to prevent an~~
1425 ~~insurer's or health maintenance organization's failure to~~
1426 ~~provide information under this subsection with respect to~~

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1427 ~~previous coverage of an individual from adversely affecting any~~
1428 ~~subsequent coverage of the individual under another group health~~
1429 ~~plan or health maintenance organization coverage.~~

1430 ~~(9) (a) A health maintenance organization may provide for~~
1431 ~~an affiliation period with respect to coverage through the~~
1432 ~~organization only if:~~

1433 ~~1. No preexisting condition exclusion is imposed with~~
1434 ~~respect to coverage through the organization;~~

1435 ~~2. The period is applied uniformly without regard to any~~
1436 ~~health status related factors; and~~

1437 ~~3. Such period does not exceed 2 months or 3 months in the~~
1438 ~~case of a late enrollee.~~

1439 ~~(b) For the purposes of this section, the term~~
1440 ~~"affiliation period" means a period that, under the terms of the~~
1441 ~~coverage offered by the health maintenance organization, must~~
1442 ~~expire before the coverage becomes effective. The organization~~
1443 ~~is not required to provide health care services or benefits~~
1444 ~~during such period, and no premium may be charged to the~~
1445 ~~participant or beneficiary for any coverage during the period.~~
1446 ~~Such period begins on the enrollment date and runs concurrently~~
1447 ~~with any waiting period under the plan.~~

1448 ~~(c) As an alternative to the method authorized by~~
1449 ~~paragraph (a), a health maintenance organization may address~~
1450 ~~adverse selection in a method approved by the office.~~

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1451 ~~(10) (a) Except as provided in paragraph (b), no period~~
1452 ~~before July 1, 1996, shall be taken into account in determining~~
1453 ~~creditable coverage.~~

1454 ~~(b) The commission shall adopt rules that provide a~~
1455 ~~process whereby individuals who need to establish creditable~~
1456 ~~coverage for periods before July 1, 1996, and who would have~~
1457 ~~such coverage credited but for paragraph (a), may be given~~
1458 ~~credit for creditable coverage for such periods through the~~
1459 ~~presentation of documents or other means.~~

1460 ~~(11) Except as otherwise provided in this subsection, the~~
1461 ~~requirements of paragraph (8) (b) shall apply to events that~~
1462 ~~occur on or after July 1, 1996.~~

1463 ~~(a) In no case is a certification required to be provided~~
1464 ~~under paragraph (8) (b) prior to June 1, 1997.~~

1465 ~~(b) In the case of an event that occurs on or after July~~
1466 ~~1, 1996, and before October 1, 1996, a certification is not~~
1467 ~~required to be provided under paragraph (8) (b), unless an~~
1468 ~~individual, with respect to whom the certification is required~~
1469 ~~to be made, requests such certification in writing.~~

1470 ~~(12) In the case of an individual who seeks to establish~~
1471 ~~creditable coverage for any period for which certification is~~
1472 ~~not required because it relates to an event occurring before~~
1473 ~~July 1, 1996:~~

1474 ~~(a) The individual may present other creditable coverage~~
1475 ~~in order to establish the period of creditable coverage.~~

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1476 ~~(b) A health maintenance organization is not subject to~~
1477 ~~any penalty or enforcement action with respect to the~~
1478 ~~organization's crediting, or not crediting, such coverage if the~~
1479 ~~organization has sought to comply in good faith with applicable~~
1480 ~~provisions of this section.~~

1481 ~~(13) For purposes of subsection (10), any plan amendment~~
1482 ~~made pursuant to a collective bargaining agreement relating to~~
1483 ~~the plan which amends the plan solely to conform to any~~
1484 ~~requirement of this section may not be treated as a termination~~
1485 ~~of such collective bargaining agreement.~~

1486 Section 21. Subsections (1), (3), and (4) of section
1487 641.31074, Florida Statutes, are amended to read:

1488 641.31074 Guaranteed renewability of coverage.—

1489 (1) Except as otherwise provided in this section, a health
1490 maintenance organization that issues a ~~group~~ health insurance
1491 contract must renew or continue in force such coverage at the
1492 option of the contract holder.

1493 (3) (a) A health maintenance organization may discontinue
1494 offering a particular contract form ~~for group coverage offered~~
1495 ~~in the small group market or large group market~~ only if:

1496 1. The health maintenance organization provides notice to
1497 each contract holder provided coverage of this form in such
1498 market, and participants and beneficiaries covered under such
1499 coverage, of such discontinuation at least 90 days prior to the
1500 date of the nonrenewal of such coverage;

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1501 2. The health maintenance organization offers to each
1502 contract holder provided coverage of this form in such market
1503 the option to purchase all, or in the case of the large group
1504 market, any other health insurance coverage currently being
1505 offered by the health maintenance organization in such market;
1506 and

1507 3. In exercising the option to discontinue coverage of
1508 this form and in offering the option of coverage under
1509 subparagraph 2., the health maintenance organization acts
1510 uniformly without regard to the claims experience of those
1511 contract holders or any health-status-related factor that
1512 relates to any participants or beneficiaries covered or new
1513 participants or beneficiaries who may become eligible for such
1514 coverage.

1515 (b)1. In any case in which a health maintenance
1516 organization elects to discontinue offering all coverage in the
1517 individual market, small group market, or the large group
1518 market, or ~~both~~ any combination thereof, in this state, coverage
1519 may be discontinued by the insurer only if:

1520 a. The health maintenance organization provides notice to
1521 the office and to each contract holder, and participants and
1522 beneficiaries covered under such coverage, of such
1523 discontinuation at least 180 days prior to the date of the
1524 nonrenewal of such coverage; and

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1525 b. All health insurance issued or delivered for issuance
1526 in this state in such market is discontinued and coverage under
1527 such health insurance coverage in such market is not renewed.

1528 2. In the case of a discontinuation under subparagraph 1.
1529 in a market, the health maintenance organization may not provide
1530 for the issuance of any health maintenance organization contract
1531 coverage in the market in this state during the 5-year period
1532 beginning on the date of the discontinuation of the last
1533 insurance contract not renewed.

1534 (4) At the time of coverage renewal, a health maintenance
1535 organization may modify the coverage for a product offered:

1536 (a) In the large group market; ~~or~~

1537 (b) In the small group market if, for coverage that is
1538 available in such market other than only through one or more
1539 bona fide associations, as defined in s. 627.6571(5), such
1540 modification is consistent with s. 627.6699 and effective on a
1541 uniform basis among group health plans with that product; or

1542 (c) In the individual market so long as such modification
1543 is consistent with the laws of this state and effective on a
1544 uniform basis among all individuals with that policy form.

1545 Section 22. Section 641.312, Florida Statutes, is amended
1546 to read:

1547 641.312 Scope.—The Office of Insurance Regulation may
1548 adopt rules to administer the provisions of the National
1549 Association of Insurance Commissioners' Uniform Health Carrier
1550 External Review Model Act, issued by the National Association of

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1551 Insurance Commissioners and dated April 2010. This section does
1552 not apply to a health maintenance contract that is subject to
1553 the Subscriber Assistance Program under s. 408.7056 or to the
1554 types of benefits or coverages provided under s. 627.6513(1)-
1555 (14) ~~627.6561(5)(b)-(e)~~ issued in any market.

1556 Section 23. This act shall take effect July 1, 2016

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1559 **T I T L E A M E N D M E N T**

1560 Remove everything before the enacting clause and insert:

1561 A bill to be entitled

1562 An act relating to health plan regulatory administration;
1563 amending s. 408.909, F.S.; redefining the term "health care
1564 coverage" or "health flex plan coverage"; amending s. 409.817,
1565 F.S.; deleting a provision authorizing group insurance plans to
1566 impose a certain preexisting condition exclusion; amending s.
1567 624.123, F.S.; conforming a cross-reference; amending s.
1568 627.402, F.S.; redefining the term "nongrandfathered health
1569 plan"; amending s. 627.411, F.S.; deleting a provision relating
1570 to a minimum loss ratio standard for specified health insurance
1571 coverage; deleting provisions specifying certain incurred
1572 claims; amending ss. 627.6011 and 627.602, incurred claims;
1573 amending ss. 627.6011 and 627.602, F.S.; conforming cross-
1574 references; amending s. 627.642, F.S.; revising the policies to
1575 which certain outline of coverage requirements apply; amending
1576 s. 627.6425, F.S.; redefining the term "individual health

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1577 insurance"; revising applicability; amending s. 627.6487, F.S.;

1578 redefining terms; repealing s. 627.64871, F.S., relating to

1579 certification of coverage; amending s. 627.6512, F.S.; revising

1580 a provision specifying that certain sections of the Florida

1581 Insurance Code do not apply to a group health insurance policy

1582 as that policy relates to specified benefits, under certain

1583 circumstances; amending s. 627.6513, F.S.; excluding

1584 applicability as to certain types of benefits or coverages;

1585 amending s. 627.6561, F.S.; revising conditions under which an

1586 insurer may impose a preexisting condition exclusion; deleting

1587 the definition of the term "creditable coverage"; removing

1588 application and reporting requirements relating to creditable

1589 coverage to conform to changes made by the act; amending s.

1590 627.6562, F.S.; redefining the term "creditable coverage";

1591 providing exceptions and applicability; amending s. 627.65626,

1592 F.S.; conforming a cross-reference; amending s. 627.6699, F.S.;

1593 redefining terms; deleting a provision that requires a certain

1594 health benefit plan to comply with specified preexisting

1595 condition provisions; conforming provisions to changes made by

1596 the act; amending s. 627.6741, F.S.; conforming cross-

1597 references; conforming a provision to changes made by the act;

1598 amending s. 641.31, F.S.; deleting a provision specifying that a

1599 law restricting or limiting deductibles, coinsurance,

1600 copayments, or annual or lifetime maximum payments may not apply

1601 to a certain health maintenance organization contract;

1602 conforming a cross-reference; amending s. 641.31071, F.S.;

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COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 951 (2016)

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1603 conforming a cross-reference; amending s. 641.31074, F.S.;

1604 revising provisions relating to guaranteed renewability of

1605 coverage; amending s. 641.312, F.S.; conforming a cross-

1606 reference; providing an effective date.