1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 408.909, F.S.; revising
4 the term "health care coverage" or "health flex plan
5 coverage"; amending s. 409.817, F.S.; deleting a
6 provision authorizing group insurance plans to impose
7 a certain preexisting condition exclusion; amending s.
8 624.123, F.S.; conforming a cross-reference; amending
9 s. 627.402, F.S.; revising the term "nongrandfathered
10 health plan"; amending s. 627.411, F.S.; deleting a
11 provision relating to a minimum loss ratio standard
12 for specified health insurance coverage; deleting
13 provisions specifying certain incurred claims;
14 repealing s. 627.6011, F.S., relating to mandated
15 coverages; amending s. 627.602, F.S.; revising
16 applicability; repealing s. 627.642, F.S., relating to
17 outline of coverage; amending s. 627.6425, F.S.;
18 revising the term "individual health insurance";
19 revising applicability; repealing s. 627.646, F.S.,
20 relating to conversion on termination of eligibility;
21 amending s. 627.6486, F.S.; conforming a cross-
22 reference; amending s. 627.6487, F.S.; revising
23 definitions; repealing s. 627.64871, F.S., relating to
24 certification of coverage; amending s. 627.6488, F.S.;
25 conforming a cross-reference; amending s. 627.6498,
26 F.S.; deleting a requirement that the Office of

27 Insurance Regulation establish certain standard risk
28 rates for coverages issued by the Florida
29 Comprehensive Health Association; amending s.
30 627.6512, F.S.; providing that certain group health
31 insurance policies are exempt from specified
32 requirements with respect to excepted benefits;
33 amending s. 627.6513, F.S.; specifying certain types
34 of benefits or coverages that are exempt; amending s.
35 627.6515, F.S.; conforming a cross-reference; deleting
36 a provision relating to a member's entitlement to
37 certain rights and options after providing a specified
38 notice of termination to an insurer; conforming a
39 provision to changes made by the act; repealing s.
40 627.6561, F.S., relating to preexisting conditions;
41 amending s. 627.6562, F.S.; redefining the term
42 "creditable coverage"; providing exceptions and
43 applicability; amending s. 627.65626, F.S.; conforming
44 a cross-reference; repealing s. 627.6675, F.S.,
45 relating to conversion on termination of eligibility;
46 amending s. 627.6699, F.S.; redefining terms; removing
47 a provision that requires a certain health benefit
48 plan to comply with specified preexisting condition
49 provisions; conforming a provision to changes made by
50 the act; amending s. 627.6741, F.S.; conforming a
51 provision to changes made by the act; conforming
52 cross-references; amending s. 641.185, F.S.; revising

53 certain standards to remove requirements for a health
54 maintenance organization to provide specified coverage
55 for preexisting conditions, provide specified
56 conversation on termination of eligibility, and
57 provide for specified conversion contracts and
58 conditions; conforming provisions to changes made by
59 the act; amending s. 641.31, F.S.; deleting a
60 provision specifying that a law restricting or
61 limiting deductibles, coinsurance, copayments, or
62 annual or lifetime maximum payments shall not apply to
63 a certain health maintenance organization contract;
64 conforming a cross-reference; repealing s. 641.31071,
65 F.S., relating to preexisting conditions; amending s.
66 641.3111, F.S.; deleting a provision specifying that a
67 subscriber is not entitled to an extension of benefits
68 under certain circumstances after termination of a
69 group health maintenance contract; amending s.
70 641.312, F.S.; conforming a cross-reference; repealing
71 ss. 641.3921 and 641.3922, F.S., relating to
72 conversion on termination of eligibility and
73 conversion contracts and conditions, respectively;
74 providing an effective date.
75
76 Be It Enacted by the Legislature of the State of Florida:
77
78 Section 1. Paragraph (d) of subsection (2) of section

79 408.909, Florida Statutes, is amended to read:
80 408.909 Health flex plans.—
81 (2) DEFINITIONS.—As used in this section, the term:
82 (d) "Health care coverage" or "health flex plan coverage"
83 means health care services that are covered as benefits under an
84 approved health flex plan or that are otherwise provided, either
85 directly or through arrangements with other persons, via a
86 health flex plan on a prepaid per capita basis or on a prepaid
87 aggregate fixed-sum basis. The terms may also include one or
88 more of the excepted benefits under s. 627.6513(1)-(13)
89 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
90 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
91 ~~as independent, noncoordinated benefits~~.
92 Section 2. Section 409.817, Florida Statutes, is amended
93 to read:
94 409.817 Approval of health benefits coverage; financial
95 assistance.—In order for health insurance coverage to qualify
96 for premium assistance payments for an eligible child under ss.
97 409.810-409.821, the health benefits coverage must:
98 (1) Be certified by the Office of Insurance Regulation of
99 the Financial Services Commission under s. 409.818 as meeting,
100 exceeding, or being actuarially equivalent to the benchmark
101 benefit plan;
102 (2) Be guarantee issued;
103 (3) Be community rated;
104 (4) Not impose any preexisting condition exclusion for

105 covered benefits; ~~however, group health insurance plans may~~
106 ~~permit the imposition of a preexisting condition exclusion, but~~
107 ~~only insofar as it is permitted under s. 627.6561;~~
108 (5) Comply with the applicable limitations on premiums and
109 cost sharing in s. 409.816;
110 (6) Comply with the quality assurance and access standards
111 developed under s. 409.820; and
112 (7) Establish periodic open enrollment periods, which may
113 not occur more frequently than quarterly.
114 Section 3. Paragraph (b) of subsection (1) of section
115 624.123, Florida Statutes, is amended to read:
116 624.123 Certain international health insurance policies;
117 exemption from code.—
118 (1) International health insurance policies and
119 applications may be solicited and sold in this state at any
120 international airport to a resident of a foreign country. Such
121 international health insurance policies shall be solicited and
122 sold only by a licensed health insurance agent and underwritten
123 only by an admitted insurer. For purposes of this subsection:
124 (b) "International health insurance policy" means health
125 insurance, as defined in s. 627.6562(3)(a)2. ~~627.6561(5)(a)2.~~,
126 which is offered to an individual, covering only a resident of a
127 foreign country on an annual basis.
128 Section 4. Subsection (2) of section 627.402, Florida
129 Statutes, is amended to read:
130 627.402 Definitions.—As used in this part, the term:

131 (2) "Nongrandfathered health plan" is a health insurance
132 policy or health maintenance organization contract that is not a
133 grandfathered health plan and does not provide the benefits or
134 coverages specified under s. 627.6513(1)-(14) ~~627.6561(5)(b)-~~
135 ~~(e)~~.
136 Section 5. Subsection (3) of section 627.411, Florida
137 Statutes, is amended to read:
138 627.411 Grounds for disapproval.—
139 ~~(3)(a) For health insurance coverage as described in s.~~
140 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
141 ~~claims to earned premium for the form shall be 65 percent.~~
142 ~~(b) Incurred claims are claims occurring within a fixed~~
143 ~~period, whether or not paid during the same period, under the~~
144 ~~terms of the policy period.~~
145 ~~1. Claims include scheduled benefit payments or services~~
146 ~~provided by a provider or through a provider network for dental,~~
147 ~~vision, disability, and similar health benefits.~~
148 ~~2. Claims do not include state assessments, taxes, company~~
149 ~~expenses, or any expense incurred by the company for the cost of~~
150 ~~adjusting and settling a claim, including the review,~~
151 ~~qualification, oversight, management, or monitoring of a claim~~
152 ~~or incentives or compensation to providers for other than the~~
153 ~~provisions of health care services.~~
154 ~~3. A company may at its discretion include costs that are~~
155 ~~demonstrated to reduce claims, such as fraud intervention~~
156 ~~programs or case management costs, which are identified in each~~

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157 ~~filing, are demonstrated to reduce claims costs, and do not~~
158 ~~result in increasing the experience period loss ratio by more~~
159 ~~than 5 percent.~~
160 ~~4. For scheduled claim payments, such as disability income~~
161 ~~or long-term care, the incurred claims shall be the present~~
162 ~~value of the benefit payments discounted for continuance and~~
163 ~~interest.~~
164 Section 6. Section 627.6011, Florida Statutes, is
165 repealed.
166 Section 7. Paragraph (h) of subsection (1) of section
167 627.602, Florida Statutes, is amended to read:
168 627.602 Scope, format of policy.—
169 (1) Each health insurance policy delivered or issued for
170 delivery to any person in this state must comply with all
171 applicable provisions of this code and all of the following
172 requirements:
173 (h) Section 641.312 and the provisions of the Employee
174 Retirement Income Security Act of 1974, as implemented by 29
175 C.F.R. s. 2560.503-1, relating to internal grievances. This
176 paragraph does not apply to a health insurance policy that is
177 subject to the Subscriber Assistance Program under s. 408.7056
178 or to the types of benefits or coverages provided under s.
179 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.
180 Section 8. Section 627.642, Florida Statutes, is repealed.
181 Section 9. Subsections (1), (6), and (7) of section
182 627.6425, Florida Statutes, are amended to read:

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183 627.6425 Renewability of individual coverage.—
184 (1) Except as otherwise provided in this section, an
185 insurer that provides individual health insurance coverage to an
186 individual shall renew or continue in force such coverage at the
187 option of the individual. For the purpose of this section, the
188 term "individual health insurance" means health insurance
189 coverage, as described in s. 624.603 ~~627.6561(5)(a)2.~~, offered
190 to an individual in this state, including certificates of
191 coverage offered to individuals in this state as part of a group
192 policy issued to an association outside this state, but the term
193 does not include short-term limited duration insurance or
194 excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
195 ~~(6) or subsection (7)~~.
196 ~~(6) The requirements of this section do not apply to any~~
197 ~~health insurance coverage in relation to its provision of~~
198 ~~excepted benefits described in s. 627.6561(5)(b).~~
199 ~~(7) The requirements of this section do not apply to any~~
200 ~~health insurance coverage in relation to its provision of~~
201 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~
202 ~~if the benefits are provided under a separate policy,~~
203 ~~certificate, or contract of insurance.~~
204 Section 10. Section 627.646, Florida Statutes, is
205 repealed.
206 Section 11. Paragraph (h) of subsection (2) of section
207 627.6486, Florida Statutes, is amended to read:
208 627.6486 Eligibility.—

209 (2)
210 (h) All eligible persons who are classified as high-risk
211 individuals pursuant to s. 627.6498(4)(a)3. ~~627.6498(4)(a)4.~~
212 shall, upon application or renewal, agree to be placed in a case
213 management system when it is determined by the board and the
214 plan case manager that such system will be cost-effective and
215 provide quality care to the individual.
216 Section 12. Paragraph (b) of subsection (2) and subsection
217 (3) of section 627.6487, Florida Statutes, are amended to read:
218 627.6487 Guaranteed availability of individual health
219 insurance coverage to eligible individuals.—
220 (2) For the purposes of this section:
221 (b) "Individual health insurance" means health insurance,
222 as defined in s. 624.603 ~~627.6561(5)(a)2.~~, which is offered to
223 an individual, including certificates of coverage offered to
224 individuals in this state as part of a group policy issued to an
225 association outside this state, but the term does not include
226 short-term limited duration insurance or excepted benefits
227 specified in s. 627.6513(1)-(14) ~~627.6561(5)(b) or, if the~~
228 ~~benefits are provided under a separate policy, certificate, or~~
229 ~~contract, the term does not include excepted benefits specified~~
230 ~~in s. 627.6561(5)(c), (d), or (e)~~.
231 (3) For the purposes of this section, the term "eligible
232 individual" means an individual:
233 (a)1. For whom, as of the date on which the individual
234 seeks coverage under this section, the aggregate of the periods

235 of creditable coverage, as defined in s. 627.6562(3) ~~627.6561(5)~~
236 ~~and (6)~~, is 18 or more months; and
237 2.a. Whose most recent prior creditable coverage was under
238 a group health plan, governmental plan, or church plan, or
239 health insurance coverage offered in connection with any such
240 plan; or
241 b. Whose most recent prior creditable coverage was under
242 an individual plan issued in this state by a health insurer or
243 health maintenance organization, which coverage is terminated
244 due to the insurer or health maintenance organization becoming
245 insolvent or discontinuing the offering of all individual
246 coverage in the State of Florida, or due to the insured no
247 longer living in the service area in the State of Florida of the
248 insurer or health maintenance organization that provides
249 coverage through a network plan in the State of Florida;
250 (b) Who is not eligible for coverage under:
251 1. A group health plan, as defined in s. 2791 of the
252 Public Health Service Act;
253 ~~2. A conversion policy or contract issued by an authorized~~
254 ~~insurer or health maintenance organization under s. 627.6675 or~~
255 ~~s. 641.3921, respectively, offered to an individual who is no~~
256 ~~longer eligible for coverage under either an insured or self-~~
257 ~~insured employer plan;~~
258 2.~~3.~~ Part A or part B of Title XVIII of the Social
259 Security Act; or
260 3.~~4.~~ A state plan under Title XIX of such act, or any

261 successor program, and does not have other health insurance
262 coverage;
263 (c) With respect to whom the most recent coverage within
264 the coverage period described in paragraph (a) was not
265 terminated based on a factor described in s. 627.6571(2)(a) or
266 (b), relating to nonpayment of premiums or fraud, unless such
267 nonpayment of premiums or fraud was due to acts of an employer
268 or person other than the individual;
269 (d) Who, having been offered the option of continuation
270 coverage under a COBRA continuation provision or under s.
271 627.6692, elected such coverage; and
272 (e) Who, if the individual elected such continuation
273 provision, has exhausted such continuation coverage under such
274 provision or program.
275 Section 13. Section 627.64871, Florida Statutes, is
276 repealed.
277 Section 14. Paragraph (h) of subsection (4) of section
278 627.6488, Florida Statutes, is amended to read:
279 627.6488 Florida Comprehensive Health Association.—
280 (4) The association shall:
281 (h) Contract with preferred provider organizations and
282 health maintenance organizations giving due consideration to the
283 preferred provider organizations and health maintenance
284 organizations which have contracted with the state group health
285 insurance program pursuant to s. 110.123. If cost-effective and
286 available in the county where the policyholder resides, the

287 board, upon application or renewal of a policy, shall place a
288 high-risk individual, as established under s. 627.6498(4)(a)3.
289 ~~627.6498(4)(a)4.~~, with the plan case manager who shall determine
290 the most cost-effective quality care system or health care
291 provider and shall place the individual in such system or with
292 such health care provider. If cost-effective and available in
293 the county where the policyholder resides, the board, with the
294 consent of the policyholder, may place a low-risk or medium-risk
295 individual, as established under s. 627.6498(4)(a)3.
296 ~~627.6498(4)(a)4.~~, with the plan case manager who may determine
297 the most cost-effective quality care system or health care
298 provider and shall place the individual in such system or with
299 such health care provider. Prior to and during the
300 implementation of case management, the plan case manager shall
301 obtain input from the policyholder, parent, or guardian.
302 Section 15. Paragraph (a) of subsection (4) of section
303 627.6498, Florida Statutes, is amended to read:
304 627.6498 Minimum benefits coverage; exclusions; premiums;
305 deductibles.—
306 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.—
307 (a) The plan shall provide for annual deductibles for
308 major medical expense coverage in the amount of $1,000 or any
309 higher amounts proposed by the board and approved by the office,
310 plus the benefits payable under any other type of insurance
311 coverage or workers' compensation. The schedule of premiums and
312 deductibles shall be established by the association. With regard

313 to any preferred provider arrangement utilized by the
314 association, the deductibles provided in this paragraph shall be
315 the minimum deductibles applicable to the preferred providers
316 and higher deductibles, as approved by the office, may be
317 applied to providers who are not preferred providers.
318 1. Separate schedules of premium rates based on age may
319 apply for individual risks.
320 2. Rates are subject to approval by the office.
321 ~~3. Standard risk rates for coverages issued by the~~
322 ~~association shall be established by the office, pursuant to s.~~
323 ~~627.6675(3).~~
324 3.~~4.~~ The board shall establish separate premium schedules
325 for low-risk individuals, medium-risk individuals, and high-risk
326 individuals and shall revise premium schedules annually
327 beginning January 1999. No rate shall exceed 200 percent of the
328 standard risk rate for low-risk individuals, 225 percent of the
329 standard risk rate for medium-risk individuals, or 250 percent
330 of the standard risk rate for high-risk individuals. For the
331 purpose of determining what constitutes a low-risk individual,
332 medium-risk individual, or high-risk individual, the board shall
333 consider the anticipated claims payment for individuals based
334 upon an individual's health condition.
335 Section 16. Section 627.6512, Florida Statutes, is amended
336 to read:
337 627.6512 Exemption of certain group health insurance
338 policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571

339 do not apply to~~:~~

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

341 provision of excepted benefits~~:~~ described in s. 627.6513(1)-(14)

342 ~~627.6561(5)(b)~~.

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

344 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~

345 ~~if the benefits:~~

346 ~~(a) Are provided under a separate policy, certificate, or~~

347 ~~contract of insurance; or~~

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

349 ~~(3) Any group health insurance policy in relation to its~~

350 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~

351 ~~if all of the following conditions are met:~~

352 ~~(a) The benefits are provided under a separate policy,~~

353 ~~certificate, or contract of insurance;~~

354 ~~(b) There is no coordination between the provision of such~~

355 ~~benefits and any exclusion of benefits under any group policy~~

356 ~~maintained by the same policyholder; and~~

357 ~~(c) Such benefits are paid with respect to an event~~

358 ~~without regard to whether benefits are provided with respect to~~

359 ~~such an event under any group health policy maintained by the~~

360 ~~same policyholder.~~

361 ~~(4) Any group health policy in relation to its provision~~

362 ~~of excepted benefits described in s. 627.6561(5)(e), if the~~

363 ~~benefits are provided under a separate policy, certificate, or~~

364 ~~contract of insurance.~~

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365 Section 17. Section 627.6513, Florida Statutes, is amended
366 to read:
367 627.6513 Scope.—Section 641.312 and the provisions of the
368 Employee Retirement Income Security Act of 1974, as implemented
369 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
370 apply to all group health insurance policies issued under this
371 part. This section does not apply to a group health insurance
372 policy that is subject to the Subscriber Assistance Program in
373 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
374 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
375 (1) Coverage only for accident, or disability income
376 insurance, or any combination thereof.
377 (2) Coverage issued as a supplement to liability
378 insurance.
379 (3) Liability insurance, including general liability
380 insurance and automobile liability insurance.
381 (4) Workers' compensation or similar insurance.
382 (5) Automobile medical payment insurance.
383 (6) Credit-only insurance.
384 (7) Coverage for onsite medical clinics, including prepaid
385 health clinics under part II of chapter 641.
386 (8) Other similar insurance coverage, specified in rules
387 adopted by the commission, under which benefits for medical care
388 are secondary or incidental to other insurance benefits. To the
389 extent possible, such rules must be consistent with regulations
390 adopted by the United States Department of Health and Human

391 Services.
392 (9) Limited scope dental or vision benefits.
393 (10) Benefits for long-term care, nursing home care, home
394 health care, community-based care, or any combination thereof.
395 (11) Other similar, limited benefits as specified in rules
396 adopted by the commission.
397 (12) Coverage only for a specified disease or illness, if
398 offered as independent, noncoordinated benefits.
399 (13) Hospital indemnity or other fixed indemnity
400 insurance, if offered as independent, noncoordinated benefits.
401 (14) Benefits provided through a Medicare supplemental
402 health insurance, as defined under s. 1882(g)(1) of the Social
403 Security Act, coverage supplemental to the coverage provided
404 under 10 U.S.C. chapter 55, and similar supplemental coverage
405 provided to coverage under a group health plan, which are
406 offered as a separate insurance policy and as independent,
407 noncoordinated benefits.
408 Section 18. Subsections (2) and (9) of section 627.6515,
409 Florida Statutes, are amended to read:
410 627.6515 Out-of-state groups.—
411 (2) Except as otherwise provided in this part, this part
412 does not apply to a group health insurance policy issued or
413 delivered outside this state under which a resident of this
414 state is provided coverage if:
415 (a) The policy is issued to an employee group the
416 composition of which is substantially as described in s.

417 627.653; a labor union group or association group the
418 composition of which is substantially as described in s.
419 627.654; an additional group the composition of which is
420 substantially as described in s. 627.656; a group insured under
421 a blanket health policy when the composition of the group is
422 substantially in compliance with s. 627.659; a group insured
423 under a franchise health policy when the composition of the
424 group is substantially in compliance with s. 627.663; an
425 association group to cover persons associated in any other
426 common group, which common group is formed primarily for
427 purposes other than providing insurance; a group that is
428 established primarily for the purpose of providing group
429 insurance, provided the benefits are reasonable in relation to
430 the premiums charged thereunder and the issuance of the group
431 policy has resulted, or will result, in economies of
432 administration; or a group of insurance agents of an insurer,
433 which insurer is the policyholder.;
434 (b) Certificates evidencing coverage under the policy are
435 issued to residents of this state and contain in contrasting
436 color and not less than 10-point type the following statement:
437 "The benefits of the policy providing your coverage are governed
438 primarily by the law of a state other than Florida."; and
439 (c) The policy provides the benefits specified in ss.
440 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121,
441 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911,
442 and complies with the requirements of s. 627.66996.

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443 (d) Applications for certificates of coverage offered to
444 residents of this state must contain, in contrasting color and
445 not less than 12-point type, the following statement on the same
446 page as the applicant's signature:
447
448 "This policy is primarily governed by the laws of
449 ...insert state where the master policy is filed....
450 As a result, all of the rating laws applicable to
451 policies filed in this state do not apply to this
452 coverage, which may result in increases in your
453 premium at renewal that would not be permissible under
454 a Florida-approved policy. Any purchase of individual
455 health insurance should be considered carefully, as
456 future medical conditions may make it impossible to
457 qualify for another individual health policy. For
458 information concerning individual health coverage
459 under a Florida-approved policy, consult your agent or
460 the Florida Department of Financial Services."
461
462 This paragraph applies only to group certificates providing
463 health insurance coverage which require individualized
464 underwriting to determine coverage eligibility for an individual
465 or premium rates to be charged to an individual except for the
466 following:
467 1. Policies issued to provide coverage to groups of
468 persons all of whom are in the same or functionally related

469 licensed professions, and providing coverage only to such
470 licensed professionals, their employees, or their dependents;
471 2. Policies providing coverage to small employers as
472 defined by s. 627.6699. Such policies shall be subject to, and
473 governed by, the provisions of s. 627.6699;
474 3. Policies issued to a bona fide association, as defined
475 by s. 627.6571(5), provided that there is a person or board
476 acting as a fiduciary for the benefit of the members, and such
477 association is not owned, controlled by, or otherwise associated
478 with the insurance company; or
479 4. Any accidental death, accidental death and
480 dismemberment, accident-only, vision-only, dental-only, hospital
481 indemnity-only, hospital accident-only, cancer, specified
482 disease, Medicare supplement, products that supplement Medicare,
483 long-term care, or disability income insurance, or similar
484 supplemental plans provided under a separate policy,
485 certificate, or contract of insurance, which cannot duplicate
486 coverage under an underlying health plan, coinsurance, or
487 deductibles or coverage issued as a supplement to workers'
488 compensation or similar insurance, or automobile medical-payment
489 insurance.
490 (9) Any insured shall be able to terminate membership or
491 affiliation with the group to whom the master policy is issued.
492 An insured that elects to terminate his or her membership or
493 affiliation with the group shall provide written notice to the
494 insurer. ~~Upon providing the written notice, the member shall be~~

495 ~~entitled to the rights and options provided by s. 627.6675.~~
496 Section 19. Section 627.6561, Florida Statutes, is
497 repealed.
498 Section 20. Subsection (3) of section 627.6562, Florida
499 Statutes, is amended to read:
500 627.6562 Dependent coverage.—
501 (3) If, pursuant to subsection (2), a child is provided
502 coverage under the parent's policy after the end of the calendar
503 year in which the child reaches age 25 and coverage for the
504 child is subsequently terminated, the child is not eligible to
505 be covered under the parent's policy unless the child was
506 continuously covered by other creditable coverage without a gap
507 in coverage of more than 63 days.
508 (a) For the purposes of this subsection, the term
509 "creditable coverage" means, with respect to an individual,
510 coverage of the individual under any of the following: ~~has the~~
511 ~~same meaning as provided in s. 627.6561(5).~~
512 1. A group health plan, as defined in s. 2791 of the
513 Public Health Service Act.
514 2. Health insurance coverage consisting of medical care
515 provided directly through insurance or reimbursement or
516 otherwise, and including terms and services paid for as medical
517 care, under any hospital or medical service policy or
518 certificate, hospital or medical service plan contract, or
519 health maintenance contract offered by a health insurance
520 issuer.

521 3. Part A or part B of Title XVIII of the Social Security
522 Act.
523 4. Title XIX of the Social Security Act, other than
524 coverage consisting solely of benefits under s. 1928.
525 5. 10 U.S.C. chapter 55.
526 6. A medical care program of the Indian Health Service or
527 of a tribal organization.
528 7. The Florida Comprehensive Health Association or another
529 state health benefit risk pool.
530 8. A health plan offered under 5 U.S.C. chapter 89.
531 9. A public health plan as defined by rules adopted by the
532 commission. To the greatest extent possible, such rules must be
533 consistent with regulations adopted by the United States
534 Department of Health and Human Services.
535 10. A health benefit plan under s. 5(e) of the Peace Corps
536 Act, 22 U.S.C. s. 2504(e).
537 (b) Creditable coverage does not include coverage that
538 consists of one or more, or any combination thereof, of the
539 following excepted benefits:
540 1. Coverage only for accident, or disability income
541 insurance, or any combination thereof.
542 2. Coverage issued as a supplement to liability insurance.
543 3. Liability insurance, including general liability
544 insurance and automobile liability insurance.
545 4. Workers' compensation or similar insurance.
546 5. Automobile medical payment insurance.

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547 6. Credit-only insurance.
548 7. Coverage for onsite medical clinics, including prepaid
549 health clinics under part II of chapter 641.
550 8. Other similar insurance coverage specified in rules
551 adopted by the commission under which benefits for medical care
552 are secondary or incidental to other insurance benefits. To the
553 extent possible, such rules must be consistent with regulations
554 adopted by the United States Department of Health and Human
555 Services.
556 (c) The following benefits are not subject to the
557 creditable coverage requirements, if offered separately:
558 1. Limited scope dental or vision benefits.
559 2. Benefits for long-term care, nursing home care, home
560 health care, community-based care, or any combination thereof.
561 3. Other similar, limited benefits as are specified in
562 rules adopted by the commission.
563 (d) The following benefits are not subject to creditable
564 coverage requirements if offered as independent, noncoordinated
565 benefits:
566 1. Coverage only for a specified disease or illness.
567 2. Hospital indemnity or other fixed indemnity insurance.
568 (e) Benefits provided through a Medicare supplemental
569 health insurance, as defined under s. 1882(g)(1) of the Social
570 Security Act, coverage supplemental to the coverage provided
571 under 10 U.S.C. chapter 55, and similar supplemental coverage
572 provided to coverage under a group health plan are not

573 considered creditable coverage if offered as a separate
574 insurance policy.
575 Section 21. Subsection (1) of section 627.65626, Florida
576 Statutes, is amended to read:
577 627.65626 Insurance rebates for healthy lifestyles.—
578 (1) Any rate, rating schedule, or rating manual for a
579 health insurance policy that provides creditable coverage as
580 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
581 shall provide for an appropriate rebate of premiums paid in the
582 last policy year, contract year, or calendar year when the
583 majority of members of a health plan have enrolled and
584 maintained participation in any health wellness, maintenance, or
585 improvement program offered by the group policyholder and health
586 plan. The rebate may be based upon premiums paid in the last
587 calendar year or policy year. The group must provide evidence of
588 demonstrative maintenance or improvement of the enrollees'
589 health status as determined by assessments of agreed-upon health
590 status indicators between the policyholder and the health
591 insurer, including, but not limited to, reduction in weight,
592 body mass index, and smoking cessation. The group or health
593 insurer may contract with a third-party administrator to
594 assemble and report the health status required in this
595 subsection between the policyholder and the health insurer. Any
596 rebate provided by the health insurer is presumed to be
597 appropriate unless credible data demonstrates otherwise, or
598 unless the rebate program requires the insured to incur costs to

599 qualify for the rebate which equal or exceed the value of the
600 rebate, but the rebate may not exceed 10 percent of paid
601 premiums.
602 Section 22. Section 627.6675, Florida Statutes, is
603 repealed.
604 Section 23. Paragraphs (e), (l), and (n) of subsection
605 (3), paragraphs (c) and (d) of subsection (5), and paragraph (b)
606 of subsection (6) of section 627.6699, Florida Statutes, are
607 amended to read:
608 627.6699 Employee Health Care Access Act.—
609 (3) DEFINITIONS.—As used in this section, the term:
610 (e) "Creditable coverage" has the same meaning ascribed in
611 s. 627.6562(3) ~~627.6561~~.
612 (l) "Late enrollee" means an eligible employee or
613 dependent who, with respect to coverage under a group health
614 policy, is a participant or beneficiary who enrolls under the
615 policy other than during:
616 1. The first period in which the individual is eligible to
617 enroll under the policy.
618 2. A special enrollment period, as provided under s.
619 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
620 (n) "Modified community rating" means a method used to
621 develop carrier premiums which spreads financial risk across a
622 large population; allows the use of separate rating factors for
623 age, gender, family composition, tobacco usage, and geographic
624 area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows

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625 adjustments for: claims experience, health status, or duration
626 of coverage as permitted under subparagraph (6)(b)5.; and
627 administrative and acquisition expenses as permitted under
628 subparagraph (6)(b)5.
629 (5) AVAILABILITY OF COVERAGE.—
630 ~~(c) Except as provided in paragraph (d), a health benefit~~
631 ~~plan covering small employers must comply with preexisting~~
632 ~~condition provisions specified in s. 627.6561 or, for health~~
633 ~~maintenance contracts, in s. 641.31071.~~
634 (c) ~~(d)~~ A health benefit plan covering small employers,
635 issued or renewed on or after January 1, 1994, must comply with
636 the following conditions:
637 1. All health benefit plans must be offered and issued on
638 a guaranteed-issue basis. Additional or increased benefits may
639 only be offered by riders.
640 ~~2. Paragraph (c) applies to health benefit plans issued to~~
641 ~~a small employer who has two or more eligible employees and to~~
642 ~~health benefit plans that are issued to a small employer who has~~
643 ~~fewer than two eligible employees and that cover an employee who~~
644 ~~has had creditable coverage continually to a date not more than~~
645 ~~63 days before the effective date of the new coverage.~~
646 2.~~3.~~ For health benefit plans that are issued to a small
647 employer who has fewer than two employees and that cover an
648 employee who has not been continually covered by creditable
649 coverage within 63 days before the effective date of the new
650 coverage, preexisting condition provisions must not exclude

651 coverage for a period beyond 24 months following the employee's
652 effective date of coverage and may relate only to:
653 a. Conditions that, during the 24-month period immediately
654 preceding the effective date of coverage, had manifested
655 themselves in such a manner as would cause an ordinarily prudent
656 person to seek medical advice, diagnosis, care, or treatment or
657 for which medical advice, diagnosis, care, or treatment was
658 recommended or received; or
659 b. A pregnancy existing on the effective date of coverage.
660 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
661 (b) For all small employer health benefit plans that are
662 subject to this section and issued by small employer carriers on
663 or after January 1, 1994, premium rates for health benefit plans
664 are subject to the following:
665 1. Small employer carriers must use a modified community
666 rating methodology in which the premium for each small employer
667 is determined solely on the basis of the eligible employee's and
668 eligible dependent's gender, age, family composition, tobacco
669 use, or geographic area as determined under paragraph (5)(e)
670 ~~(5)(f)~~ and in which the premium may be adjusted as permitted by
671 this paragraph. A small employer carrier is not required to use
672 gender as a rating factor for a nongrandfathered health plan.
673 2. Rating factors related to age, gender, family
674 composition, tobacco use, or geographic location may be
675 developed by each carrier to reflect the carrier's experience.
676 The factors used by carriers are subject to office review and

677 approval.
678 3. Small employer carriers may not modify the rate for a
679 small employer for 12 months from the initial issue date or
680 renewal date, unless the composition of the group changes or
681 benefits are changed. However, a small employer carrier may
682 modify the rate one time within the 12 months after the initial
683 issue date for a small employer who enrolls under a previously
684 issued group policy that has a common anniversary date for all
685 employers covered under the policy if:
686 a. The carrier discloses to the employer in a clear and
687 conspicuous manner the date of the first renewal and the fact
688 that the premium may increase on or after that date.
689 b. The insurer demonstrates to the office that
690 efficiencies in administration are achieved and reflected in the
691 rates charged to small employers covered under the policy.
692 4. A carrier may issue a group health insurance policy to
693 a small employer health alliance or other group association with
694 rates that reflect a premium credit for expense savings
695 attributable to administrative activities being performed by the
696 alliance or group association if such expense savings are
697 specifically documented in the insurer's rate filing and are
698 approved by the office. Any such credit may not be based on
699 different morbidity assumptions or on any other factor related
700 to the health status or claims experience of any person covered
701 under the policy. This subparagraph does not exempt an alliance
702 or group association from licensure for activities that require

703 licensure under the insurance code. A carrier issuing a group
704 health insurance policy to a small employer health alliance or
705 other group association shall allow any properly licensed and
706 appointed agent of that carrier to market and sell the small
707 employer health alliance or other group association policy. Such
708 agent shall be paid the usual and customary commission paid to
709 any agent selling the policy.
710 5. Any adjustments in rates for claims experience, health
711 status, or duration of coverage may not be charged to individual
712 employees or dependents. For a small employer's policy, such
713 adjustments may not result in a rate for the small employer
714 which deviates more than 15 percent from the carrier's approved
715 rate. Any such adjustment must be applied uniformly to the rates
716 charged for all employees and dependents of the small employer.
717 A small employer carrier may make an adjustment to a small
718 employer's renewal premium, up to 10 percent annually, due to
719 the claims experience, health status, or duration of coverage of
720 the employees or dependents of the small employer. If the
721 aggregate resulting from the application of such adjustment
722 exceeds the premium that would have been charged by application
723 of the approved modified community rate by 4 percent for the
724 current policy term, the carrier shall limit the application of
725 such adjustments only to minus adjustments. For any subsequent
726 policy term, if the total aggregate adjusted premium actually
727 charged does not exceed the premium that would have been charged
728 by application of the approved modified community rate by 4

729 percent, the carrier may apply both plus and minus adjustments.
730 A small employer carrier may provide a credit to a small
731 employer's premium based on administrative and acquisition
732 expense differences resulting from the size of the group. Group
733 size administrative and acquisition expense factors may be
734 developed by each carrier to reflect the carrier's experience
735 and are subject to office review and approval.
736 6. A small employer carrier rating methodology may include
737 separate rating categories for one dependent child, for two
738 dependent children, and for three or more dependent children for
739 family coverage of employees having a spouse and dependent
740 children or employees having dependent children only. A small
741 employer carrier may have fewer, but not greater, numbers of
742 categories for dependent children than those specified in this
743 subparagraph.
744 7. Small employer carriers may not use a composite rating
745 methodology to rate a small employer with fewer than 10
746 employees. For the purposes of this subparagraph, the term
747 "composite rating methodology" means a rating methodology that
748 averages the impact of the rating factors for age and gender in
749 the premiums charged to all of the employees of a small
750 employer.
751 8. A carrier may separate the experience of small employer
752 groups with fewer than 2 eligible employees from the experience
753 of small employer groups with 2-50 eligible employees for
754 purposes of determining an alternative modified community

755 rating.
756 a. If a carrier separates the experience of small employer
757 groups, the rate to be charged to small employer groups of fewer
758 than 2 eligible employees may not exceed 150 percent of the rate
759 determined for small employer groups of 2-50 eligible employees.
760 However, the carrier may charge excess losses of the experience
761 pool consisting of small employer groups with less than 2
762 eligible employees to the experience pool consisting of small
763 employer groups with 2-50 eligible employees so that all losses
764 are allocated and the 150-percent rate limit on the experience
765 pool consisting of small employer groups with less than 2
766 eligible employees is maintained.
767 b. Notwithstanding s. 627.411(1), the rate to be charged
768 to a small employer group of fewer than 2 eligible employees,
769 insured as of July 1, 2002, may be up to 125 percent of the rate
770 determined for small employer groups of 2-50 eligible employees
771 for the first annual renewal and 150 percent for subsequent
772 annual renewals.
773 9. A carrier shall separate the experience of
774 grandfathered health plans from nongrandfathered health plans
775 for determining rates.
776 Section 24. Subsection (1) and paragraph (c) of subsection
777 (2) of section 627.6741, Florida Statutes, are amended to read:
778 627.6741 Issuance, cancellation, nonrenewal, and
779 replacement.—
780 (1)(a) An insurer issuing Medicare supplement policies in

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781 this state shall offer the opportunity of enrolling in a
782 Medicare supplement policy, without conditioning the issuance or
783 effectiveness of the policy on, and without discriminating in
784 the price of the policy based on, the medical or health status
785 or receipt of health care by the individual:
786 1. To any individual who is 65 years of age or older, or
787 under 65 years of age and eligible for Medicare by reason of
788 disability or end-stage renal disease, and who resides in this
789 state, upon the request of the individual during the 6-month
790 period beginning with the first month in which the individual
791 has attained 65 years of age and is enrolled in Medicare Part B,
792 or is eligible for Medicare by reason of a disability or end-
793 stage renal disease, and is enrolled in Medicare Part B; or
794 2. To any individual who is 65 years of age or older, or
795 under 65 years of age and eligible for Medicare by reason of a
796 disability or end-stage renal disease, who is enrolled in
797 Medicare Part B, and who resides in this state, upon the request
798 of the individual during the 2-month period following
799 termination of coverage under a group health insurance policy.
800 (b) The 6-month period to enroll in a Medicare supplement
801 policy for an individual who is under 65 years of age and is
802 eligible for Medicare by reason of disability or end-stage renal
803 disease and otherwise eligible under subparagraph (a)1. or
804 subparagraph (a)2. and first enrolled in Medicare Part B before
805 October 1, 2009, begins on October 1, 2009.
806 (c) A company that has offered Medicare supplement

807 policies to individuals under 65 years of age who are eligible
808 for Medicare by reason of disability or end-stage renal disease
809 before October 1, 2009, may, for one time only, effect a rate
810 schedule change that redefines the age bands of the premium
811 classes without activating the period of discontinuance required
812 by s. 627.410(6)(e)2.
813 (d) As a part of an insurer's rate filings, before and
814 including the insurer's first rate filing for a block of policy
815 forms in 2015, notwithstanding the provisions of s.
816 627.410(6)(e)3., an insurer shall consider the experience of the
817 policies or certificates for the premium classes including
818 individuals under 65 years of age and eligible for Medicare by
819 reason of disability or end-stage renal disease separately from
820 the balance of the block so as not to affect the other premium
821 classes. For filings in such time period only, credibility of
822 that experience shall be as follows: if a block of policy forms
823 has 1,250 or more policies or certificates in force in the age
824 band including ages under 65 years of age, full or 100-percent
825 credibility shall be given to the experience; and if fewer than
826 250 policies or certificates are in force, no or zero-percent
827 credibility shall be given. Linear interpolation shall be used
828 for in-force amounts between the low and high values. Florida-
829 only experience shall be used if it is 100-percent credible. If
830 Florida-only experience is not 100-percent credible, a
831 combination of Florida-only and nationwide experience shall be
832 used. If Florida-only experience is zero-percent credible,

833 nationwide experience shall be used. The insurer may file its
834 initial rates and any rate adjustment based upon the experience
835 of these policies or certificates or based upon expected claim
836 experience using experience data of the same company, other
837 companies in the same or other states, or using data publicly
838 available from the Centers for Medicaid and Medicare Services if
839 the insurer's combined Florida and nationwide experience is not
840 100-percent credible, separate from the balance of all other
841 Medicare supplement policies.
842
843 A Medicare supplement policy issued to an individual under
844 subparagraph (a)1. or subparagraph (a)2. may not exclude
845 benefits based on a preexisting condition if the individual has
846 a continuous period of creditable coverage, as defined in s.
847 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
848 application for coverage.
849 (2) For both individual and group Medicare supplement
850 policies:
851 (c) If a Medicare supplement policy or certificate
852 replaces another Medicare supplement policy or certificate or
853 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
854 the replacing insurer shall waive any time periods applicable to
855 preexisting conditions, waiting periods, elimination periods,
856 and probationary periods in the new Medicare supplement policy
857 for similar benefits to the extent such time was spent under the
858 original policy~~, subject to the requirements of s. 627.6561(6)~~.

859 ~~(11)~~.
860 Section 25. Paragraphs (f) and (h) of subsection (1) of
861 section 641.185, Florida Statutes, are amended to read:
862 641.185 Health maintenance organization subscriber
863 protections.—
864 (1) With respect to the provisions of this part and part
865 III, the principles expressed in the following statements shall
866 serve as standards to be followed by the commission, the office,
867 the department, and the Agency for Health Care Administration in
868 exercising their powers and duties, in exercising administrative
869 discretion, in administrative interpretations of the law, in
870 enforcing its provisions, and in adopting rules:
871 (f) A health maintenance organization subscriber should
872 receive the flexibility to transfer to another Florida health
873 maintenance organization, regardless of health status, pursuant
874 to ss. 641.228, 641.3104, <u>and</u> ~~641.3107,~~ 641.3111~~, 641.3921, and~~
875 ~~641.3922~~.
876 (h) A health maintenance organization that issues a group
877 health contract must~~: provide coverage for preexisting~~
878 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
879 coverage pursuant to s. 641.31074<u>,</u>~~;~~ provide notice of
880 cancellation pursuant to s. 641.3108<u>, and</u>~~;~~ provide extension of
881 benefits pursuant to s. 641.3111~~; provide for conversion on~~
882 ~~termination of eligibility pursuant to s. 641.3921; and provide~~
883 ~~for conversion contracts and conditions pursuant to s. 641.3922~~.
884 Section 26. Subsection (2) and paragraph (a) of subsection

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885 (40) of section 641.31, Florida Statutes, are amended to read:
886 641.31 Health maintenance contracts.—
887 (2) The rates charged by any health maintenance
888 organization to its subscribers shall not be excessive,
889 inadequate, or unfairly discriminatory or follow a rating
890 methodology that is inconsistent, indeterminate, or ambiguous or
891 encourages misrepresentation or misunderstanding. ~~A law~~
892 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
893 ~~annual or lifetime maximum payments shall not apply to any~~
894 ~~health maintenance organization contract that provides coverage~~
895 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
896 ~~individual or a group of 51 or more persons.~~ The commission, in
897 accordance with generally accepted actuarial practice as applied
898 to health maintenance organizations, may define by rule what
899 constitutes excessive, inadequate, or unfairly discriminatory
900 rates and may require whatever information it deems necessary to
901 determine that a rate or proposed rate meets the requirements of
902 this subsection.
903 (40)(a) Any group rate, rating schedule, or rating manual
904 for a health maintenance organization policy, which provides
905 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
906 filed with the office shall provide for an appropriate rebate of
907 premiums paid in the last policy year, contract year, or
908 calendar year when the majority of members of a health plan are
909 enrolled in and have maintained participation in any health
910 wellness, maintenance, or improvement program offered by the

911 group contract holder. The group must provide evidence of
912 demonstrative maintenance or improvement of his or her health
913 status as determined by assessments of agreed-upon health status
914 indicators between the group and the health insurer, including,
915 but not limited to, reduction in weight, body mass index, and
916 smoking cessation. Any rebate provided by the health maintenance
917 organization is presumed to be appropriate unless credible data
918 demonstrates otherwise, or unless the rebate program requires
919 the insured to incur costs to qualify for the rebate which
920 equals or exceeds the value of the rebate but the rebate may not
921 exceed 10 percent of paid premiums.
922 Section 27. Section 641.31071, Florida Statutes, is
923 repealed.
924 Section 28. Subsection (4) of section 641.3111, Florida
925 Statutes, is amended to read:
926 641.3111 Extension of benefits.—
927 ~~(4) Except as provided in subsection (1), no subscriber is~~
928 ~~entitled to an extension of benefits if the termination of the~~
929 ~~contract by the health maintenance organization is based upon~~
930 ~~any event referred to in s. 641.3922(7)(a), (b), or (c).~~
931 Section 29. Section 641.312, Florida Statutes, is amended
932 to read:
933 641.312 Scope.—The Office of Insurance Regulation may
934 adopt rules to administer the provisions of the National
935 Association of Insurance Commissioners' Uniform Health Carrier
936 External Review Model Act, issued by the National Association of

937 Insurance Commissioners and dated April 2010. This section does
938 not apply to a health maintenance contract that is subject to
939 the Subscriber Assistance Program under s. 408.7056 or to the
940 types of benefits or coverages provided under s. 627.6513(1)-
941 (14) ~~627.6561(5)(b)-(e)~~ issued in any market.
942 Section 30. Sections 641.3921 and 641.3922, Florida
943 Statutes, are repealed.
944 Section 31. This act shall take effect July 1, 2016.