

1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 408.909, F.S.; redefining
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.; redefining 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 amending ss. 627.6011 and 627.602, F.S.; conforming
15 cross-references; amending s. 627.642, F.S.; providing
16 requirements for certain policies offering benefits
17 and large group policies; amending s. 627.6425, F.S.;
18 redefining the term "individual health insurance";
19 revising applicability; amending s. 627.6487, F.S.;
20 redefining terms; repealing s. 627.64871, F.S.,
21 relating to certification of coverage; amending s.
22 627.6512, F.S.; revising provisions exempting certain
23 group health insurance policies from specified
24 requirements with respect to excepted benefits;
25 amending s. 627.6513, F.S.; revising certain types of
26 benefits or coverages that are exempt; amending s.

27 | 627.6561, F.S.; revising conditions under which an
 28 | insurer may impose a preexisting condition exclusion;
 29 | deleting the definition of the term "creditable
 30 | coverage"; removing certain requirements relating to
 31 | creditable coverage to conform to changes made by the
 32 | act; amending s. 627.6562, F.S.; redefining the term
 33 | "creditable coverage"; providing exceptions and
 34 | applicability; amending s. 627.65626, F.S.; conforming
 35 | a cross-reference; amending s. 627.6699, F.S.;
 36 | redefining terms; deleting a provision that requires a
 37 | certain health benefit plan to comply with specified
 38 | preexisting condition provisions; amending s.
 39 | 627.6741, F.S.; conforming cross-references;
 40 | conforming a provision to changes made by the act;
 41 | amending s. 641.31, F.S.; deleting a provision
 42 | specifying that a law restricting or limiting
 43 | deductibles, coinsurance, copayments, or annual or
 44 | lifetime maximum payments may not apply to a certain
 45 | health maintenance organization contract; conforming a
 46 | cross-reference; amending s. 641.31071, F.S.;
 47 | conforming a cross-reference; deleting the definition
 48 | of the term "creditable coverage"; removing certain
 49 | requirements relating to creditable coverage to
 50 | conform to changes made by the act; amending s.
 51 | 641.31074; revising requirements for health
 52 | maintenance organizations to renew or continue health

53 insurance contracts under certain conditions; revising
 54 conditions in which a health maintenance organization
 55 may discontinue certain coverage; providing conditions
 56 in which a health maintenance organization may modify
 57 certain coverage; amending s. 641.312, F.S.;
 58 conforming a cross-reference; providing an effective
 59 date.

60

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

62

63 Section 1. Paragraph (d) of subsection (2) of section
 64 408.909, Florida Statutes, is amended to read:

65 408.909 Health flex plans.—

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

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

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

79 409.817 Approval of health benefits coverage; financial
 80 assistance.—In order for health insurance coverage to qualify
 81 for premium assistance payments for an eligible child under ss.
 82 409.810-409.821, the health benefits coverage must:

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

87 (2) Be guarantee issued;

88 (3) Be community rated;

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

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

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

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

99 Section 3. Paragraph (b) of subsection (1) of section
 100 624.123, Florida Statutes, is amended to read:

101 624.123 Certain international health insurance policies;
 102 exemption from code.—

103 (1) International health insurance policies and
 104 applications may be solicited and sold in this state at any

105 international airport to a resident of a foreign country. Such
 106 international health insurance policies shall be solicited and
 107 sold only by a licensed health insurance agent and underwritten
 108 only by an admitted insurer. For purposes of this subsection:

109 (b) "International health insurance policy" means health
 110 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2.
 111 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
 112 only a resident of a foreign country on an annual basis.

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

115 627.402 Definitions.—As used in this part, the term:

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

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

123 627.411 Grounds for disapproval.—

124 ~~(3)(a) For health insurance coverage as described in s.~~
 125 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
 126 ~~claims to earned premium for the form shall be 65 percent.~~

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

130 ~~1. Claims include scheduled benefit payments or services~~

131 ~~provided by a provider or through a provider network for dental,~~
132 ~~vision, disability, and similar health benefits.~~

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

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

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

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

151 627.6011 Mandated coverages.—Mandatory health benefits
152 regulated under this chapter are not intended to apply to the
153 types of health benefit plans listed in s. 627.6513(1)-(14)
154 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically
155 designated otherwise. For purposes of this section, the term
156 "mandatory health benefits" means those benefits set forth in

157 ss. 627.6401-627.64193, and any other mandatory treatment or
 158 health coverages or benefits enacted on or after July 1, 2012.

159 Section 7. Paragraph (h) of subsection (1) of section
 160 627.602, Florida Statutes, is amended to read:

161 627.602 Scope, format of policy.—

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

166 (h) Section 641.312 and the provisions of the Employee
 167 Retirement Income Security Act of 1974, as implemented by 29
 168 C.F.R. s. 2560.503-1, relating to internal grievances. This
 169 paragraph does not apply to a health insurance policy that is
 170 subject to the Subscriber Assistance Program under s. 408.7056
 171 or to the types of benefits or coverages provided under s.
 172 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.

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

175 627.642 Outline of coverage.—

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

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

182 (b) An appropriate outline of coverage is completed and

183 delivered to the applicant at the time application is made, and
 184 an acknowledgment of receipt or certificate of delivery of such
 185 outline is provided to the insurer with the application.

186
 187 In the case of a direct response, such as a written application
 188 to the insurance company from an applicant, the outline of
 189 coverage shall accompany the policy when issued.

190 Section 9. Subsections (1), (6), and (7) of section
 191 627.6425, Florida Statutes, are amended to read:

192 627.6425 Renewability of individual coverage.—

193 (1) Except as otherwise provided in this section, an
 194 insurer that provides individual health insurance coverage to an
 195 individual shall renew or continue in force such coverage at the
 196 option of the individual. For the purpose of this section, the
 197 term "individual health insurance" means health insurance
 198 coverage, as described in s. 624.603 ~~627.6561(5)(a)2.~~, offered
 199 to an individual in this state, including certificates of
 200 coverage offered to individuals in this state as part of a group
 201 policy issued to an association outside this state, but the term
 202 does not include short-term limited duration insurance or
 203 excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
 204 ~~(6) or subsection (7).~~

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

208 ~~(7) The requirements of this section do not apply to any~~

209 ~~health insurance coverage in relation to its provision of~~
 210 ~~excepted benefits described in s. 627.6561(5) (c), (d), or (e),~~
 211 ~~if the benefits are provided under a separate policy,~~
 212 ~~certificate, or contract of insurance.~~

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

216 627.6487 Guaranteed availability of individual health
 217 insurance coverage to eligible individuals.-

218 (2) For the purposes of this section:

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

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

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

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

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

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

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

252 627.6512 Exemption of certain group health insurance
 253 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571
 254 do not apply to÷

255 ~~(1)~~ any group insurance policy in relation to its
 256 provision of ~~excepted~~ benefits described in s. 627.6513(1)-(14)
 257 ~~627.6561(5)(b).~~

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

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

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

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

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

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

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

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

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

282 627.6513 Scope.—Section 641.312 and the provisions of the
 283 Employee Retirement Income Security Act of 1974, as implemented
 284 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
 285 apply to all group health insurance policies issued under this
 286 part. This section does not apply to a group health insurance

287 policy that is subject to the Subscriber Assistance Program in
 288 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
 289 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~

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

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

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

296 (4) Workers' compensation or similar insurance.

297 (5) Automobile medical payment insurance.

298 (6) Credit-only insurance.

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

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

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

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

312 (11) Other similar, limited benefits, if offered

313 separately, as specified in rules adopted by the commission.

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

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

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

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

327 627.6561 Preexisting conditions.—

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

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

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

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

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

339 627.65615.

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

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

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

354 (b) Such exclusion extends for a period of not more than
355 12 months, or 18 months in the case of a late enrollee, after
356 the enrollment date; and

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

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

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

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

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

377 3. Pregnancy.

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

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

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

386 ~~2. Health insurance coverage consisting of medical care,~~
 387 ~~provided directly, through insurance or reimbursement, or~~
 388 ~~otherwise and including terms and services paid for as medical~~
 389 ~~care, under any hospital or medical service policy or~~
 390 ~~certificate, hospital or medical service plan contract, or~~

391 ~~health maintenance contract offered by a health insurance~~
 392 ~~issuer.~~

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

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

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

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

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

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

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

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

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

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

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

416 ~~3. Liability insurance, including general liability~~

417 ~~insurance and automobile liability insurance.~~

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

419 ~~5. Automobile medical payment insurance.~~

420 ~~6. Credit-only insurance.~~

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

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

423 ~~8. Other similar insurance coverage, specified in rules~~

424 ~~adopted by the commission, under which benefits for medical care~~

425 ~~are secondary or incidental to other insurance benefits. To the~~

426 ~~extent possible, such rules must be consistent with regulations~~

427 ~~adopted by the United States Department of Health and Human~~

428 ~~Services.~~

429 ~~(c) The following benefits are not subject to the~~

430 ~~creditable coverage requirements, if offered separately:~~

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

432 ~~2. Benefits for long-term care, nursing home care, home~~

433 ~~health care, community-based care, or any combination thereof.~~

434 ~~3. Such other similar, limited benefits as are specified~~

435 ~~in rules adopted by the commission.~~

436 ~~(d) The following benefits are not subject to creditable~~

437 ~~coverage requirements if offered as independent, noncoordinated~~

438 ~~benefits:~~

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

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

441 ~~(e) Benefits provided through a Medicare supplemental~~

442 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~

443 ~~Security Act, coverage supplemental to the coverage provided~~
444 ~~under chapter 55 of Title 10, United States Code, and similar~~
445 ~~supplemental coverage provided to coverage under a group health~~
446 ~~plan are not considered creditable coverage if offered as a~~
447 ~~separate insurance policy.~~

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

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

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

461 ~~(b) An insurer may elect to count, as creditable coverage,~~
462 ~~coverage of benefits within each of several classes or~~
463 ~~categories of benefits specified in rules adopted by the~~
464 ~~commission rather than as provided under paragraph (a). To the~~
465 ~~extent possible, such rules must be consistent with regulations~~
466 ~~adopted by the United States Department of Health and Human~~
467 ~~Services. Such election shall be made on a uniform basis for all~~
468 ~~participants and beneficiaries. Under such election, an insurer~~

469 ~~shall count a period of creditable coverage with respect to any~~
470 ~~class or category of benefits if any level of benefits is~~
471 ~~covered within such class or category.~~

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

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

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

480 ~~(8) (a) Periods of creditable coverage with respect to an~~
481 ~~individual shall be established through presentation of~~
482 ~~certifications described in this subsection or in such other~~
483 ~~manner as is specified in rules adopted by the commission. To~~
484 ~~the extent possible, such rules must be consistent with~~
485 ~~regulations adopted by the United States Department of Health~~
486 ~~and Human Services.~~

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

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

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

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

498
 499 ~~The certification under subparagraph 1. may be provided, to the~~
 500 ~~extent practicable, at a time consistent with notices required~~
 501 ~~under any applicable COBRA continuation provision or~~
 502 ~~continuation pursuant to s. 627.6692.~~

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

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

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

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

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

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

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

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

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

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

541 ~~(10) Except as otherwise provided in this subsection,~~
542 ~~paragraph (8) (b) applies to events that occur on or after July~~
543 ~~1, 1996.~~

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

546 ~~(b) In the case of an event that occurred on or after July~~

547 ~~1, 1996, and before October 1, 1996, a certification is not~~
548 ~~required to be provided under paragraph (8) (b), unless an~~
549 ~~individual, with respect to whom the certification is required~~
550 ~~to be made, requests such certification in writing.~~

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

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

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

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

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

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

573 ~~insurance.~~

574 ~~(15) This section applies to health insurance coverage~~
 575 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
 576 ~~1997.~~

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

579 627.6562 Dependent coverage.—

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

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

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

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

599 issuer.

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

601 Act.

602 4. Title XIX of the Social Security Act, other than

603 coverage consisting solely of benefits under s. 1928.

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

605 6. A medical care program of the Indian Health Service or

606 of a tribal organization.

607 7. The Florida Comprehensive Health Association or another

608 state health benefit risk pool.

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

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

611 commission. To the greatest extent possible, such rules must be

612 consistent with regulations adopted by the United States

613 Department of Health and Human Services.

614 10. A health benefit plan under s. 5(e) of the Peace Corps

615 Act, 22 U.S.C. s. 2504(e).

616 (b) Creditable coverage does not include coverage that

617 consists of one or more, or any combination thereof, of the

618 following excepted benefits:

619 1. Coverage only for accident insurance, or disability

620 income insurance, or any combination thereof.

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

622 3. Liability insurance, including general liability

623 insurance and automobile liability insurance.

624 4. Workers' compensation or similar insurance.

- 625 5. Automobile medical payment insurance.
- 626 6. Credit-only insurance.
- 627 7. Coverage for onsite medical clinics, including prepaid
628 health clinics under part II of chapter 641.
- 629 8. Other similar insurance coverage specified in rules
630 adopted by the commission under which benefits for medical care
631 are secondary or incidental to other insurance benefits. To the
632 extent possible, such rules must be consistent with regulations
633 adopted by the United States Department of Health and Human
634 Services.
- 635 (c) The following benefits are not subject to the
636 creditable coverage requirements, if offered separately:
- 637 1. Limited scope dental or vision benefits.
- 638 2. Benefits for long-term care, nursing home care, home
639 health care, community-based care, or any combination thereof.
- 640 3. Other similar, limited benefits specified in rules
641 adopted by the commission.
- 642 (d) The following benefits are not subject to creditable
643 coverage requirements if offered as independent, noncoordinated
644 benefits:
- 645 1. Coverage only for a specified disease or illness.
- 646 2. Hospital indemnity or other fixed indemnity insurance.
- 647 (e) Benefits provided through a Medicare supplemental
648 health insurance policy, as defined under s. 1882(g)(1) of the
649 Social Security Act, coverage supplemental to the coverage
650 provided under 10 U.S.C. chapter 55, and similar supplemental

651 coverage provided to coverage under a group health plan are not
652 considered creditable coverage if offered as a separate
653 insurance policy.

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

656 627.65626 Insurance rebates for healthy lifestyles.—

657 (1) Any rate, rating schedule, or rating manual for a
658 health insurance policy that provides creditable coverage as
659 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
660 shall provide for an appropriate rebate of premiums paid in the
661 last policy year, contract year, or calendar year when the
662 majority of members of a health plan have enrolled and
663 maintained participation in any health wellness, maintenance, or
664 improvement program offered by the group policyholder and health
665 plan. The rebate may be based upon premiums paid in the last
666 calendar year or policy year. The group must provide evidence of
667 demonstrative maintenance or improvement of the enrollees'
668 health status as determined by assessments of agreed-upon health
669 status indicators between the policyholder and the health
670 insurer, including, but not limited to, reduction in weight,
671 body mass index, and smoking cessation. The group or health
672 insurer may contract with a third-party administrator to
673 assemble and report the health status required in this
674 subsection between the policyholder and the health insurer. Any
675 rebate provided by the health insurer is presumed to be
676 appropriate unless credible data demonstrates otherwise, or

677 unless the rebate program requires the insured to incur costs to
 678 qualify for the rebate which equal or exceed the value of the
 679 rebate, but the rebate may not exceed 10 percent of paid
 680 premiums.

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

684 627.6699 Employee Health Care Access Act.—

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

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

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

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

694 2. A special enrollment period, as provided under s.
 695 627.65615 ~~as defined under s. 627.6561(1)(b).~~

696 (5) AVAILABILITY OF COVERAGE.—

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

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

703 ~~2. Paragraph (c) applies to health benefit plans issued to~~
704 ~~a small employer who has two or more eligible employees and to~~
705 ~~health benefit plans that are issued to a small employer who has~~
706 ~~fewer than two eligible employees and that cover an employee who~~
707 ~~has had creditable coverage continually to a date not more than~~
708 ~~63 days before the effective date of the new coverage.~~

709 2.3. For health benefit plans that are issued to a small
710 employer who has fewer than two employees and that cover an
711 employee who has not been continually covered by creditable
712 coverage within 63 days before the effective date of the new
713 coverage, preexisting condition provisions must not exclude
714 coverage for a period beyond 24 months following the employee's
715 effective date of coverage and may relate only to:

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

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

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

725 627.6741 Issuance, cancellation, nonrenewal, and
726 replacement.—

727 (1) (a) An insurer issuing Medicare supplement policies in
728 this state shall offer the opportunity of enrolling in a

729 Medicare supplement policy, without conditioning the issuance or
730 effectiveness of the policy on, and without discriminating in
731 the price of the policy based on, the medical or health status
732 or receipt of health care by the individual:

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

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

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

753 (c) A company that has offered Medicare supplement
754 policies to individuals under 65 years of age who are eligible

755 for Medicare by reason of disability or end-stage renal disease
756 before October 1, 2009, may, for one time only, effect a rate
757 schedule change that redefines the age bands of the premium
758 classes without activating the period of discontinuance required
759 by s. 627.410(6)(e)2.

760 (d) As a part of an insurer's rate filings, before and
761 including the insurer's first rate filing for a block of policy
762 forms in 2015, notwithstanding the provisions of s.
763 627.410(6)(e)3., an insurer shall consider the experience of the
764 policies or certificates for the premium classes including
765 individuals under 65 years of age and eligible for Medicare by
766 reason of disability or end-stage renal disease separately from
767 the balance of the block so as not to affect the other premium
768 classes. For filings in such time period only, credibility of
769 that experience shall be as follows: if a block of policy forms
770 has 1,250 or more policies or certificates in force in the age
771 band including ages under 65 years of age, full or 100-percent
772 credibility shall be given to the experience; and if fewer than
773 250 policies or certificates are in force, no or zero-percent
774 credibility shall be given. Linear interpolation shall be used
775 for in-force amounts between the low and high values. Florida-
776 only experience shall be used if it is 100-percent credible. If
777 Florida-only experience is not 100-percent credible, a
778 combination of Florida-only and nationwide experience shall be
779 used. If Florida-only experience is zero-percent credible,
780 nationwide experience shall be used. The insurer may file its

781 initial rates and any rate adjustment based upon the experience
782 of these policies or certificates or based upon expected claim
783 experience using experience data of the same company, other
784 companies in the same or other states, or using data publicly
785 available from the Centers for Medicaid and Medicare Services if
786 the insurer's combined Florida and nationwide experience is not
787 100-percent credible, separate from the balance of all other
788 Medicare supplement policies.

789

790 A Medicare supplement policy issued to an individual under
791 subparagraph (a)1. or subparagraph (a)2. may not exclude
792 benefits based on a preexisting condition if the individual has
793 a continuous period of creditable coverage, as defined in s.
794 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
795 application for coverage.

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

798 (c) If a Medicare supplement policy or certificate
799 replaces another Medicare supplement policy or certificate or
800 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
801 the replacing insurer shall waive any time periods applicable to
802 preexisting conditions, waiting periods, elimination periods,
803 and probationary periods in the new Medicare supplement policy
804 for similar benefits to the extent such time was spent under the
805 original policy, ~~subject to the requirements of s. 627.6561(6)~~
806 ~~(11)~~.

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

809 641.31 Health maintenance contracts.—

810 (2) The rates charged by any health maintenance
 811 organization to its subscribers shall not be excessive,
 812 inadequate, or unfairly discriminatory or follow a rating
 813 methodology that is inconsistent, indeterminate, or ambiguous or
 814 encourages misrepresentation or misunderstanding. ~~A law~~
 815 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
 816 ~~annual or lifetime maximum payments shall not apply to any~~
 817 ~~health maintenance organization contract that provides coverage~~
 818 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
 819 ~~individual or a group of 51 or more persons.~~ The commission, in
 820 accordance with generally accepted actuarial practice as applied
 821 to health maintenance organizations, may define by rule what
 822 constitutes excessive, inadequate, or unfairly discriminatory
 823 rates and may require whatever information it deems necessary to
 824 determine that a rate or proposed rate meets the requirements of
 825 this subsection.

826 (40) (a) Any group rate, rating schedule, or rating manual
 827 for a health maintenance organization policy, which provides
 828 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
 829 filed with the office shall provide for an appropriate rebate of
 830 premiums paid in the last policy year, contract year, or
 831 calendar year when the majority of members of a health plan are
 832 enrolled in and have maintained participation in any health

833 wellness, maintenance, or improvement program offered by the
834 group contract holder. The group must provide evidence of
835 demonstrative maintenance or improvement of his or her health
836 status as determined by assessments of agreed-upon health status
837 indicators between the group and the health insurer, including,
838 but not limited to, reduction in weight, body mass index, and
839 smoking cessation. Any rebate provided by the health maintenance
840 organization is presumed to be appropriate unless credible data
841 demonstrates otherwise, or unless the rebate program requires
842 the insured to incur costs to qualify for the rebate which
843 equals or exceeds the value of the rebate but the rebate may not
844 exceed 10 percent of paid premiums.

845 Section 20. Section 641.31071, Florida Statutes, is
846 amended to read:

847 641.31071 Preexisting conditions.—

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

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

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

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

859 2. A special enrollment period, as provided under s.
860 641.31072.

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

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

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

876 (b) Such exclusion extends for a period of not more than
877 12 months, or 18 months in the case of a late enrollee, after
878 the enrollment date; and

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

884 (3) Genetic information shall not be treated as a

885 condition described in paragraph (2)(a) in the absence of a
 886 diagnosis of the condition related to such information.

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

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

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

899 3. Pregnancy.

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

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

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

909 ~~2. Health insurance coverage consisting of medical care,~~
 910 ~~provided directly, through insurance or reimbursement or~~

911 ~~otherwise, and including terms and services paid for as medical~~
912 ~~care, under any hospital or medical service policy or~~
913 ~~certificate, hospital or medical service plan contract, or~~
914 ~~health maintenance contract offered by a health insurance~~
915 ~~issuer.~~

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

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

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

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

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

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

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

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

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

936 ~~1. Coverage only for accident, or disability income~~

937 ~~insurance, or any combination thereof.~~

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

939 ~~3. Liability insurance, including general liability~~

940 ~~insurance and automobile liability insurance.~~

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

942 ~~5. Automobile medical payment insurance.~~

943 ~~6. Credit-only insurance.~~

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

945 ~~8. Other similar insurance coverage, specified in rules~~

946 ~~adopted by the commission, under which benefits for medical care~~

947 ~~are secondary or incidental to other insurance benefits. To the~~

948 ~~greatest extent possible, such rules must be consistent with~~

949 ~~regulations adopted by the United States Department of Health~~

950 ~~and Human Services.~~

951 ~~(c) The following benefits are not subject to the~~

952 ~~creditable coverage requirements, if offered separately;~~

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

954 ~~2. Benefits or long-term care, nursing home care, home~~

955 ~~health care, community-based care, or any combination of these.~~

956 ~~3. Such other similar, limited benefits as are specified~~

957 ~~in rules adopted by the commission. To the greatest extent~~

958 ~~possible, such rules must be consistent with regulations adopted~~

959 ~~by the United States Department of Health and Human Services.~~

960 ~~(d) The following benefits are not subject to creditable~~

961 ~~coverage requirements if offered as independent, noncoordinated~~

962 ~~benefits:~~

963 ~~1. Coverage only for a specified disease or illness.~~
 964 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
 965 ~~(e) Benefits provided through Medicare supplemental health~~
 966 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
 967 ~~Act, coverage supplemental to the coverage provided under~~
 968 ~~chapter 55 of Title 10, United States Code, and similar~~
 969 ~~supplemental coverage provided to coverage under a group health~~
 970 ~~plan are not considered creditable coverage if offered as a~~
 971 ~~separate insurance policy.~~

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

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

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

988 ~~(b) A health maintenance organization may elect to count~~

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

998 ~~(c) In the case of an election with respect to a health~~
 999 ~~maintenance organization under paragraph (b), the organization~~
 1000 ~~shall:~~

1001 ~~1. Prominently state in 10-point type or larger in any~~
 1002 ~~disclosure statements concerning the contract, and state to each~~
 1003 ~~enrollee at the time of enrollment under the contract, that the~~
 1004 ~~organization has made such election; and~~

1005 ~~2. Include in such statements a description of the effect~~
 1006 ~~of this election.~~

1007 ~~(8)(a) Periods of creditable coverage with respect to an~~
 1008 ~~individual shall be established through presentation of~~
 1009 ~~certifications described in this subsection or in such other~~
 1010 ~~manner as may be specified in rules adopted by the commission.~~

1011 ~~(b) A health maintenance organization that offers group~~
 1012 ~~coverage shall provide the certification described in paragraph~~
 1013 ~~(a):~~

1014 ~~1. At the time an individual ceases to be covered under~~

1015 ~~the plan or otherwise becomes covered under a COBRA continuation~~
 1016 ~~provision or continuation pursuant to s. 627.6692.~~

1017 ~~2. In the case of an individual becoming covered under a~~
 1018 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
 1019 ~~time the individual ceases to be covered under such a provision.~~

1020 ~~3. Upon the request on behalf of an individual made not~~
 1021 ~~later than 24 months after the date of cessation of the coverage~~
 1022 ~~described in this paragraph.~~

1023
 1024 ~~The certification under subparagraph 1. may be provided, to the~~
 1025 ~~extent practicable, at a time consistent with notices required~~
 1026 ~~under any applicable COBRA continuation provision or~~
 1027 ~~continuation pursuant to s. 627.6692.~~

1028 ~~(c) The certification is a written certification of:~~

1029 ~~1. The period of creditable coverage of the individual~~
 1030 ~~under the contract and the coverage, if any, under such COBRA~~
 1031 ~~continuation provision or continuation pursuant to s. 627.6692;~~
 1032 ~~and~~

1033 ~~2. The waiting period, if any, imposed with respect to the~~
 1034 ~~individual for any coverage under such contract.~~

1035 ~~(d) In the case of an election described in subsection (7)~~
 1036 ~~by a health maintenance organization, if the organization~~
 1037 ~~enrolls an individual for coverage under the plan and the~~
 1038 ~~individual provides a certification of coverage of the~~
 1039 ~~individual, as provided by this subsection:~~

1040 ~~1. Upon request of such health maintenance organization,~~

1041 ~~the insurer or health maintenance organization that issued the~~
 1042 ~~certification provided by the individual shall promptly disclose~~
 1043 ~~to such requesting organization information on coverage of~~
 1044 ~~classes and categories of health benefits available under such~~
 1045 ~~insurer's or health maintenance organization's plan or coverage.~~

1046 ~~2. Such insurer or health maintenance organization may~~
 1047 ~~charge the requesting organization for the reasonable cost of~~
 1048 ~~disclosing such information.~~

1049 ~~(c) The commission shall adopt rules to prevent an~~
 1050 ~~insurer's or health maintenance organization's failure to~~
 1051 ~~provide information under this subsection with respect to~~
 1052 ~~previous coverage of an individual from adversely affecting any~~
 1053 ~~subsequent coverage of the individual under another group health~~
 1054 ~~plan or health maintenance organization coverage.~~

1055 ~~(9) (a) A health maintenance organization may provide for~~
 1056 ~~an affiliation period with respect to coverage through the~~
 1057 ~~organization only if:~~

1058 ~~1. No preexisting condition exclusion is imposed with~~
 1059 ~~respect to coverage through the organization;~~

1060 ~~2. The period is applied uniformly without regard to any~~
 1061 ~~health status related factors; and~~

1062 ~~3. Such period does not exceed 2 months or 3 months in the~~
 1063 ~~ease of a late enrollee.~~

1064 ~~(b) For the purposes of this section, the term~~
 1065 ~~"affiliation period" means a period that, under the terms of the~~
 1066 ~~coverage offered by the health maintenance organization, must~~

1067 ~~expire before the coverage becomes effective. The organization~~
1068 ~~is not required to provide health care services or benefits~~
1069 ~~during such period, and no premium may be charged to the~~
1070 ~~participant or beneficiary for any coverage during the period.~~
1071 ~~Such period begins on the enrollment date and runs concurrently~~
1072 ~~with any waiting period under the plan.~~

1073 ~~(c) As an alternative to the method authorized by~~
1074 ~~paragraph (a), a health maintenance organization may address~~
1075 ~~adverse selection in a method approved by the office.~~

1076 ~~(10) (a) Except as provided in paragraph (b), no period~~
1077 ~~before July 1, 1996, shall be taken into account in determining~~
1078 ~~creditable coverage.~~

1079 ~~(b) The commission shall adopt rules that provide a~~
1080 ~~process whereby individuals who need to establish creditable~~
1081 ~~coverage for periods before July 1, 1996, and who would have~~
1082 ~~such coverage credited but for paragraph (a), may be given~~
1083 ~~credit for creditable coverage for such periods through the~~
1084 ~~presentation of documents or other means.~~

1085 ~~(11) Except as otherwise provided in this subsection, the~~
1086 ~~requirements of paragraph (8) (b) shall apply to events that~~
1087 ~~occur on or after July 1, 1996.~~

1088 ~~(a) In no case is a certification required to be provided~~
1089 ~~under paragraph (8) (b) prior to June 1, 1997.~~

1090 ~~(b) In the case of an event that occurs on or after July~~
1091 ~~1, 1996, and before October 1, 1996, a certification is not~~
1092 ~~required to be provided under paragraph (8) (b), unless an~~

1093 ~~individual, with respect to whom the certification is required~~
 1094 ~~to be made, requests such certification in writing.~~

1095 ~~(12) In the case of an individual who seeks to establish~~
 1096 ~~creditable coverage for any period for which certification is~~
 1097 ~~not required because it relates to an event occurring before~~
 1098 ~~July 1, 1996:~~

1099 ~~(a) The individual may present other creditable coverage~~
 1100 ~~in order to establish the period of creditable coverage.~~

1101 ~~(b) A health maintenance organization is not subject to~~
 1102 ~~any penalty or enforcement action with respect to the~~
 1103 ~~organization's crediting, or not crediting, such coverage if the~~
 1104 ~~organization has sought to comply in good faith with applicable~~
 1105 ~~provisions of this section.~~

1106 ~~(13) For purposes of subsection (10), any plan amendment~~
 1107 ~~made pursuant to a collective bargaining agreement relating to~~
 1108 ~~the plan which amends the plan solely to conform to any~~
 1109 ~~requirement of this section may not be treated as a termination~~
 1110 ~~of such collective bargaining agreement.~~

1111 Section 21. Subsections (1), (3), and (4) of section
 1112 641.31074, Florida Statutes, are amended to read:

1113 641.31074 Guaranteed renewability of coverage.—

1114 (1) Except as otherwise provided in this section, a health
 1115 maintenance organization that issues a ~~group~~ health insurance
 1116 contract must renew or continue in force such coverage at the
 1117 option of the contract holder.

1118 (3) (a) A health maintenance organization may discontinue

1119 offering a particular contract form ~~for group coverage offered~~
 1120 ~~in the small group market or large group market~~ only if:

1121 1. The health maintenance organization provides notice to
 1122 each contract holder provided coverage of this form in such
 1123 market, and participants and beneficiaries covered under such
 1124 coverage, of such discontinuation at least 90 days prior to the
 1125 date of the nonrenewal of such coverage;

1126 2. The health maintenance organization offers to each
 1127 contract holder provided coverage of this form in such market
 1128 the option to purchase all, or in the case of the large group
 1129 market, any other health insurance coverage currently being
 1130 offered by the health maintenance organization in such market;
 1131 and

1132 3. In exercising the option to discontinue coverage of
 1133 this form and in offering the option of coverage under
 1134 subparagraph 2., the health maintenance organization acts
 1135 uniformly without regard to the claims experience of those
 1136 contract holders or any health-status-related factor that
 1137 relates to any participants or beneficiaries covered or new
 1138 participants or beneficiaries who may become eligible for such
 1139 coverage.

1140 (b)1. In any case in which a health maintenance
 1141 organization elects to discontinue offering all coverage in the
 1142 individual market, small group market, or the large group
 1143 market, or any combination thereof ~~both~~, in this state, coverage
 1144 may be discontinued by the insurer only if:

1145 a. The health maintenance organization provides notice to
 1146 the office and to each contract holder, and participants and
 1147 beneficiaries covered under such coverage, of such
 1148 discontinuation at least 180 days prior to the date of the
 1149 nonrenewal of such coverage; and

1150 b. All health insurance issued or delivered for issuance
 1151 in this state in such market is discontinued and coverage under
 1152 such health insurance coverage in such market is not renewed.

1153 2. In the case of a discontinuation under subparagraph 1.
 1154 in a market, the health maintenance organization may not provide
 1155 for the issuance of any health maintenance organization contract
 1156 coverage in the market in this state during the 5-year period
 1157 beginning on the date of the discontinuation of the last
 1158 insurance contract not renewed.

1159 (4) At the time of coverage renewal, a health maintenance
 1160 organization may modify the coverage for a product offered:

1161 (a) In the large group market; or

1162 (b) In the small group market if, for coverage that is
 1163 available in such market other than only through one or more
 1164 bona fide associations, as defined in s. 627.6571(5), such
 1165 modification is consistent with s. 627.6699 and effective on a
 1166 uniform basis among group health plans with that product; or

1167 (c) In the individual market if the modification is
 1168 consistent with the laws of this state and effective on a
 1169 uniform basis among all individuals with that policy form.

1170 Section 22. Section 641.312, Florida Statutes, is amended

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2016

1171 to read:

1172 641.312 Scope.—The Office of Insurance Regulation may
1173 adopt rules to administer the provisions of the National
1174 Association of Insurance Commissioners' Uniform Health Carrier
1175 External Review Model Act, issued by the National Association of
1176 Insurance Commissioners and dated April 2010. This section does
1177 not apply to a health maintenance contract that is subject to
1178 the Subscriber Assistance Program under s. 408.7056 or to the
1179 types of benefits or coverages provided under s. 627.6513(1)-
1180 (14) ~~627.6561(5)(b)-(e)~~ issued in any market.

1181 Section 23. This act shall take effect July 1, 2016.