

1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 112.08, F.S.; authorizing
4 local governmental units to contract with certain not-
5 for-profit corporations to provide certain group
6 insurance for its officers and employees; amending s.
7 408.909, F.S.; redefining the term "health care
8 coverage" or "health flex plan coverage"; amending s.
9 409.817, F.S.; deleting a provision authorizing group
10 insurance plans to impose a certain preexisting
11 condition exclusion; amending s. 624.123, F.S.;
12 conforming a cross-reference; amending s. 626.88,
13 F.S.; revising the definition of the term
14 "administrator"; amending s. 627.402, F.S.; redefining
15 the term nongrandfathered health plan"; amending s.
16 627.411, F.S.; deleting a provision relating to a
17 minimum loss ratio standard for specified health
18 insurance coverage; deleting provisions specifying
19 certain incurred claims; amending ss. 627.6011 and
20 627.602, F.S.; conforming cross-references; amending
21 s. 627.642, F.S.; providing requirements for certain
22 policies offering specified benefits; amending s.
23 627.6425, F.S.; redefining the term "individual health
24 insurance"; revising applicability; amending s.
25 627.6487, F.S.; redefining terms; repealing s.
26 627.64871, F.S., relating to certification of

27 coverage; amending s. 627.6512, F.S.; revising
28 provisions exempting certain group health insurance
29 policies from specified requirements with respect to
30 excepted benefits; amending s. 627.6513, F.S.;
31 revising certain types of benefits or coverages that
32 are exempt; amending s. 627.6561, F.S.; revising
33 conditions under which an insurer may impose a
34 preexisting condition exclusion; deleting the
35 definition of the term "creditable coverage"; removing
36 certain requirements relating to creditable coverage
37 to conform to changes made by the act; amending s.
38 627.6562, F.S.; redefining the term "creditable
39 coverage"; providing exceptions and applicability;
40 amending s. 627.65626, F.S.; conforming a cross-
41 reference; amending s. 627.6699, F.S.; redefining
42 terms; deleting a provision that requires a certain
43 health benefit plan to comply with specified
44 preexisting condition provisions; amending s.
45 627.6741, F.S.; conforming cross-references;
46 conforming a provision to changes made by the act;
47 amending s. 641.31, F.S.; deleting a provision
48 specifying that a law restricting or limiting
49 deductibles, coinsurance, copayments, or annual or
50 lifetime maximum payments may not apply to a certain
51 health maintenance organization contract; conforming a
52 cross-reference; amending s. 641.31071, F.S.;

53 conforming a cross-reference; deleting the definition
 54 of the term "creditable coverage"; removing certain
 55 requirements relating to creditable coverage to
 56 conform to changes made by the act; amending s.
 57 641.31074; revising requirements for health
 58 maintenance organizations to renew or continue health
 59 insurance contracts under certain conditions; revising
 60 conditions in which a health maintenance organization
 61 may discontinue certain coverage; providing conditions
 62 in which a health maintenance organization may modify
 63 certain coverage; amending s. 641.312, F.S.;
 64 conforming a cross-reference; providing an effective
 65 date.

66
 67 Be It Enacted by the Legislature of the State of Florida:

68
 69 Section 1. Paragraph (a) of subsection (2) of section
 70 112.08, Florida Statutes, is amended to read:

71 112.08 Group insurance for public officers, employees, and
 72 certain volunteers; physical examinations.-

73 (2) (a) Notwithstanding any general law or special act to
 74 the contrary, every local governmental unit is authorized to
 75 provide and pay out of its available funds for all or part of
 76 the premium for life, health, accident, hospitalization, legal
 77 expense, or annuity insurance, or all or any kinds of such
 78 insurance, for the officers and employees of the local

79 governmental unit and for health, accident, hospitalization, and
80 legal expense insurance for the dependents of such officers and
81 employees upon a group insurance plan and, to that end, to enter
82 into contracts with insurance companies, ~~or~~ professional
83 administrators, or a corporation not for profit whose membership
84 consists entirely of local governmental units authorized to
85 enter into risk management consortiums under this subsection to
86 provide such insurance. Before entering any contract for
87 insurance, the local governmental unit shall advertise for
88 competitive bids; and such contract shall be let upon the basis
89 of such bids. If a contracting health insurance provider becomes
90 financially impaired as determined by the Office of Insurance
91 Regulation of the Financial Services Commission or otherwise
92 fails or refuses to provide the contracted-for coverage or
93 coverages, the local government may purchase insurance, enter
94 into risk management programs, or contract with third-party
95 administrators and may make such acquisitions by advertising for
96 competitive bids or by direct negotiations and contract. The
97 local governmental unit may undertake simultaneous negotiations
98 with those companies which have submitted reasonable and timely
99 bids and are found by the local governmental unit to be fully
100 qualified and capable of meeting all servicing requirements.
101 Each local governmental unit may self-insure any plan for
102 health, accident, and hospitalization coverage or enter into a
103 risk management consortium to provide such coverage, subject to
104 approval based on actuarial soundness by the Office of Insurance

105 Regulation; and each shall contract with an insurance company or
106 professional administrator qualified and approved by the office
107 to administer such a plan or with a corporation not for profit
108 whose membership consists entirely of local governmental units
109 authorized to enter into risk management consortiums under this
110 subsection.

111 Section 2. Paragraph (d) of subsection (2) of section
112 408.909, Florida Statutes, is amended to read:

113 408.909 Health flex plans.—

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

115 (d) "Health care coverage" or "health flex plan coverage"
116 means health care services that are covered as benefits under an
117 approved health flex plan or that are otherwise provided, either
118 directly or through arrangements with other persons, via a
119 health flex plan on a prepaid per capita basis or on a prepaid
120 aggregate fixed-sum basis. The terms may also include one or
121 more of the excepted benefits under s. 627.6513(1)-(13)
122 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
123 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
124 ~~as independent, noncoordinated benefits.~~

125 Section 3. Section 409.817, Florida Statutes, is amended
126 to read:

127 409.817 Approval of health benefits coverage; financial
128 assistance.—In order for health insurance coverage to qualify
129 for premium assistance payments for an eligible child under ss.
130 409.810-409.821, the health benefits coverage must:

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

135 (2) Be guarantee issued;

136 (3) Be community rated;

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

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

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

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

147 Section 4. Paragraph (b) of subsection (1) of section
 148 624.123, Florida Statutes, is amended to read:

149 624.123 Certain international health insurance policies;
 150 exemption from code.—

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

157 (b) "International health insurance policy" means health
 158 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2.
 159 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
 160 only a resident of a foreign country on an annual basis.

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

163 626.88 Definitions.—For the purposes of this part, the
 164 term:

165 (1) "Administrator" is any person who directly or
 166 indirectly solicits or effects coverage of, collects charges or
 167 premiums from, or adjusts or settles claims on residents of this
 168 state in connection with authorized commercial self-insurance
 169 funds or with insured or self-insured programs which provide
 170 life or health insurance coverage or coverage of any other
 171 expenses described in s. 624.33(1) or any person who, through a
 172 health care risk contract as defined in s. 641.234 with an
 173 insurer or health maintenance organization, provides billing and
 174 collection services to health insurers and health maintenance
 175 organizations on behalf of health care providers, other than any
 176 of the following persons:

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

180
 181 A person who provides billing and collection services to health
 182 insurers and health maintenance organizations on behalf of

183 health care providers shall comply with the provisions of ss.
 184 627.6131, 641.3155, and 641.51(4).

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

187 627.402 Definitions.—As used in this part, the term:

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

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

195 627.411 Grounds for disapproval.—

196 ~~(3)(a) For health insurance coverage as described in s.~~
 197 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
 198 ~~claims to earned premium for the form shall be 65 percent.~~

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

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

205 ~~2. Claims do not include state assessments, taxes, company~~
 206 ~~expenses, or any expense incurred by the company for the cost of~~
 207 ~~adjusting and settling a claim, including the review,~~
 208 ~~qualification, oversight, management, or monitoring of a claim~~

209 ~~or incentives or compensation to providers for other than the~~
210 ~~provisions of health care services.~~

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

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

221 Section 8. Section 627.6011, Florida Statutes, is amended
222 to read:

223 627.6011 Mandated coverages.—Mandatory health benefits
224 regulated under this chapter are not intended to apply to the
225 types of health benefit plans listed in s. 627.6513(1)-(14)
226 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically
227 designated otherwise. For purposes of this section, the term
228 "mandatory health benefits" means those benefits set forth in
229 ss. 627.6401-627.64193, and any other mandatory treatment or
230 health coverages or benefits enacted on or after July 1, 2012.

231 Section 9. Paragraph (h) of subsection (1) of section
232 627.602, Florida Statutes, is amended to read:

233 627.602 Scope, format of policy.—

234 (1) Each health insurance policy delivered or issued for

235 delivery to any person in this state must comply with all
 236 applicable provisions of this code and all of the following
 237 requirements:

238 (h) Section 641.312 and the provisions of the Employee
 239 Retirement Income Security Act of 1974, as implemented by 29
 240 C.F.R. s. 2560.503-1, relating to internal grievances. This
 241 paragraph does not apply to a health insurance policy that is
 242 subject to the Subscriber Assistance Program under s. 408.7056
 243 or to the types of benefits or coverages provided under s.
 244 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.

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

247 627.642 Outline of coverage.—

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

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

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

258
 259 In the case of a direct response, such as a written application
 260 to the insurance company from an applicant, the outline of

261 coverage shall accompany the policy when issued.

262 Section 11. Subsections (1), (6), and (7) of section
263 627.6425, Florida Statutes, are amended to read:

264 627.6425 Renewability of individual coverage.—

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

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

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

285 Section 12. Paragraph (b) of subsection (2) and paragraph
286 (a) of subsection (3) of section 627.6487, Florida Statutes, are

287 amended to read:

288 627.6487 Guaranteed availability of individual health
289 insurance coverage to eligible individuals.—

290 (2) For the purposes of this section:

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

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

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

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

311 b. Whose most recent prior creditable coverage was under
312 an individual plan issued in this state by a health insurer or

313 health maintenance organization, which coverage is terminated
 314 due to the insurer or health maintenance organization becoming
 315 insolvent or discontinuing the offering of all individual
 316 coverage in the State of Florida, or due to the insured no
 317 longer living in the service area in the State of Florida of the
 318 insurer or health maintenance organization that provides
 319 coverage through a network plan in the State of Florida;

320 Section 13. Section 627.64871, Florida Statutes, is
 321 repealed.

322 Section 14. Section 627.6512, Florida Statutes, is amended
 323 to read:

324 627.6512 Exemption of certain group health insurance
 325 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571
 326 do not apply to:

327 ~~(1) any group insurance policy in relation to its~~
 328 ~~provision of excepted benefits described in s. 627.6513(1)-(14)~~
 329 ~~627.6561(5)(b).~~

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

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

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

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

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

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

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

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

352 Section 15. Section 627.6513, Florida Statutes, is amended
 353 to read:

354 627.6513 Scope.—Section 641.312 and the provisions of the
 355 Employee Retirement Income Security Act of 1974, as implemented
 356 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
 357 apply to all group health insurance policies issued under this
 358 part. This section does not apply to a group health insurance
 359 policy that is subject to the Subscriber Assistance Program in
 360 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
 361 ~~under s. 627.6561(5)(b)-(c) issued in any market.~~

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

364 (2) Coverage issued as a supplement to liability

- 365 insurance.
- 366 (3) Liability insurance, including general liability
367 insurance and automobile liability insurance.
- 368 (4) Workers' compensation or similar insurance.
- 369 (5) Automobile medical payment insurance.
- 370 (6) Credit-only insurance.
- 371 (7) Coverage for onsite medical clinics, including prepaid
372 health clinics under part II of chapter 641.
- 373 (8) Other similar insurance coverage, specified in rules
374 adopted by the commission, under which benefits for medical care
375 are secondary or incidental to other insurance benefits. To the
376 extent possible, such rules must be consistent with regulations
377 adopted by the United States Department of Health and Human
378 Services.
- 379 (9) Limited scope dental or vision benefits, if offered
380 separately.
- 381 (10) Benefits for long-term care, nursing home care, home
382 health care, or community-based care, or any combination
383 thereof, if offered separately.
- 384 (11) Other similar, limited benefits, if offered
385 separately, as specified in rules adopted by the commission.
- 386 (12) Coverage only for a specified disease or illness, if
387 offered as independent, noncoordinated benefits.
- 388 (13) Hospital indemnity or other fixed indemnity
389 insurance, if offered as independent, noncoordinated benefits.
- 390 (14) Benefits provided through a Medicare supplemental

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

397 Section 16. Section 627.6561, Florida Statutes, is amended
398 to read:

399 627.6561 Preexisting conditions.—

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

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

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

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

410 2. A special enrollment period, as provided under s.
411 627.65615.

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

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

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

426 (b) Such exclusion extends for a period of not more than
427 12 months, or 18 months in the case of a late enrollee, after
428 the enrollment date; and

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

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

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

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

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

449 3. Pregnancy.

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

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

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

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

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

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

- 469 ~~5. Chapter 55 of Title 10, United States Code.~~
- 470 ~~6. A medical care program of the Indian Health Service or~~
 471 ~~of a tribal organization.~~
- 472 ~~7. The Florida Comprehensive Health Association or another~~
 473 ~~state health benefit risk pool.~~
- 474 ~~8. A health plan offered under chapter 89 of Title 5,~~
 475 ~~United States Code.~~
- 476 ~~9. A public health plan as defined by rules adopted by the~~
 477 ~~commission. To the greatest extent possible, such rules must be~~
 478 ~~consistent with regulations adopted by the United States~~
 479 ~~Department of Health and Human Services.~~
- 480 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
 481 ~~Act (22 U.S.C. s. 2504(e)).~~
- 482 ~~(b) Creditable coverage does not include coverage that~~
 483 ~~consists solely of one or more or any combination thereof of the~~
 484 ~~following excepted benefits:~~
- 485 ~~1. Coverage only for accident, or disability income~~
 486 ~~insurance, or any combination thereof.~~
- 487 ~~2. Coverage issued as a supplement to liability insurance.~~
- 488 ~~3. Liability insurance, including general liability~~
 489 ~~insurance and automobile liability insurance.~~
- 490 ~~4. Workers' compensation or similar insurance.~~
- 491 ~~5. Automobile medical payment insurance.~~
- 492 ~~6. Credit-only insurance.~~
- 493 ~~7. Coverage for onsite medical clinics, including prepaid~~
 494 ~~health clinics under part II of chapter 641.~~

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

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

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

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

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

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

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

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

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

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

521 ~~with respect to enrollment of an individual under a group health~~
522 ~~plan, if, after such period and before the enrollment date,~~
523 ~~there was a 63-day period during all of which the individual was~~
524 ~~not covered under any creditable coverage.~~

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

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

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

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

546 ~~1. Prominently state in 10-point type or larger in any~~

547 ~~disclosure statements concerning the policy, and state to each~~
548 ~~certificateholder at the time of enrollment under the policy,~~
549 ~~that the insurer has made such election; and~~

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

552 ~~(8)(a) Periods of creditable coverage with respect to an~~
553 ~~individual shall be established through presentation of~~
554 ~~certifications described in this subsection or in such other~~
555 ~~manner as is specified in rules adopted by the commission. To~~
556 ~~the extent possible, such rules must be consistent with~~
557 ~~regulations adopted by the United States Department of Health~~
558 ~~and Human Services.~~

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

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

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

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

570

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

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

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

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

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

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

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

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

594 ~~(e) The commission shall adopt rules to prevent an~~
595 ~~insurer's failure to provide information under this subsection~~
596 ~~with respect to previous coverage of an individual from~~
597 ~~adversely affecting any subsequent coverage of the individual~~
598 ~~under another group health plan or health insurance coverage. To~~

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

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

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

613 ~~(10) Except as otherwise provided in this subsection,~~
614 ~~paragraph (8) (b) applies to events that occur on or after July~~
615 ~~1, 1996.~~

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

618 ~~(b) In the case of an event that occurred on or after July~~
619 ~~1, 1996, and before October 1, 1996, a certification is not~~
620 ~~required to be provided under paragraph (8) (b), unless an~~
621 ~~individual, with respect to whom the certification is required~~
622 ~~to be made, requests such certification in writing.~~

623 ~~(11) In the case of an individual who seeks to establish~~
624 ~~creditable coverage for any period for which certification is~~

625 ~~not required because it relates to an event that occurred before~~
626 ~~July 1, 1996.~~

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

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

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

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

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

646 ~~(15) This section applies to health insurance coverage~~
647 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
648 ~~1997.~~

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

651 627.6562 Dependent coverage.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

696 4. Workers' compensation or similar insurance.

697 5. Automobile medical payment insurance.

698 6. Credit-only insurance.

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

701 8. Other similar insurance coverage specified in rules
 702 adopted by the commission under which benefits for medical care

703 are secondary or incidental to other insurance benefits. To the
704 extent possible, such rules must be consistent with regulations
705 adopted by the United States Department of Health and Human
706 Services.

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

- 709 1. Limited scope dental or vision benefits.
710 2. Benefits for long-term care, nursing home care, home
711 health care, community-based care, or any combination thereof.
712 3. Other similar, limited benefits specified in rules
713 adopted by the commission.

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

- 717 1. Coverage only for a specified disease or illness.
718 2. Hospital indemnity or other fixed indemnity insurance.

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

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

728 627.65626 Insurance rebates for healthy lifestyles.—

729 (1) Any rate, rating schedule, or rating manual for a
730 health insurance policy that provides creditable coverage as
731 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
732 shall provide for an appropriate rebate of premiums paid in the
733 last policy year, contract year, or calendar year when the
734 majority of members of a health plan have enrolled and
735 maintained participation in any health wellness, maintenance, or
736 improvement program offered by the group policyholder and health
737 plan. The rebate may be based upon premiums paid in the last
738 calendar year or policy year. The group must provide evidence of
739 demonstrative maintenance or improvement of the enrollees'
740 health status as determined by assessments of agreed-upon health
741 status indicators between the policyholder and the health
742 insurer, including, but not limited to, reduction in weight,
743 body mass index, and smoking cessation. The group or health
744 insurer may contract with a third-party administrator to
745 assemble and report the health status required in this
746 subsection between the policyholder and the health insurer. Any
747 rebate provided by the health insurer is presumed to be
748 appropriate unless credible data demonstrates otherwise, or
749 unless the rebate program requires the insured to incur costs to
750 qualify for the rebate which equal or exceed the value of the
751 rebate, but the rebate may not exceed 10 percent of paid
752 premiums.

753 Section 19. Paragraphs (e) and (l) of subsection (3) and
754 paragraph (d) of subsection (5) of section 627.6699, Florida

755 Statutes, are amended to read:

756 627.6699 Employee Health Care Access Act.—

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

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

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

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

766 2. A special enrollment period, as provided under s.
767 627.65615 as defined under s. 627.6561(1)(b).

768 (5) AVAILABILITY OF COVERAGE.—

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

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

775 2. ~~Paragraph (c) applies to health benefit plans issued to~~
776 ~~a small employer who has two or more eligible employees and to~~
777 ~~health benefit plans that are issued to a small employer who has~~
778 ~~fewer than two eligible employees and that cover an employee who~~
779 ~~has had creditable coverage continually to a date not more than~~
780 ~~63 days before the effective date of the new coverage.~~

781 ~~2.3.~~ For health benefit plans that are issued to a small
782 employer who has fewer than two employees and that cover an
783 employee who has not been continually covered by creditable
784 coverage within 63 days before the effective date of the new
785 coverage, preexisting condition provisions must not exclude
786 coverage for a period beyond 24 months following the employee's
787 effective date of coverage and may relate only to:

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

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

795 Section 20. Subsection (1) and paragraph (c) of subsection
796 (2) of section 627.6741, Florida Statutes, are amended to read:

797 627.6741 Issuance, cancellation, nonrenewal, and
798 replacement.—

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

805 1. To any individual who is 65 years of age or older, or
806 under 65 years of age and eligible for Medicare by reason of

807 disability or end-stage renal disease, and who resides in this
808 state, upon the request of the individual during the 6-month
809 period beginning with the first month in which the individual
810 has attained 65 years of age and is enrolled in Medicare Part B,
811 or is eligible for Medicare by reason of a disability or end-
812 stage renal disease, and is enrolled in Medicare Part B; or

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

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

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

832 (d) As a part of an insurer's rate filings, before and

833 including the insurer's first rate filing for a block of policy
834 forms in 2015, notwithstanding the provisions of s.
835 627.410(6)(e)3., an insurer shall consider the experience of the
836 policies or certificates for the premium classes including
837 individuals under 65 years of age and eligible for Medicare by
838 reason of disability or end-stage renal disease separately from
839 the balance of the block so as not to affect the other premium
840 classes. For filings in such time period only, credibility of
841 that experience shall be as follows: if a block of policy forms
842 has 1,250 or more policies or certificates in force in the age
843 band including ages under 65 years of age, full or 100-percent
844 credibility shall be given to the experience; and if fewer than
845 250 policies or certificates are in force, no or zero-percent
846 credibility shall be given. Linear interpolation shall be used
847 for in-force amounts between the low and high values. Florida-
848 only experience shall be used if it is 100-percent credible. If
849 Florida-only experience is not 100-percent credible, a
850 combination of Florida-only and nationwide experience shall be
851 used. If Florida-only experience is zero-percent credible,
852 nationwide experience shall be used. The insurer may file its
853 initial rates and any rate adjustment based upon the experience
854 of these policies or certificates or based upon expected claim
855 experience using experience data of the same company, other
856 companies in the same or other states, or using data publicly
857 available from the Centers for Medicaid and Medicare Services if
858 the insurer's combined Florida and nationwide experience is not

859 100-percent credible, separate from the balance of all other
 860 Medicare supplement policies.

861
 862 A Medicare supplement policy issued to an individual under
 863 subparagraph (a)1. or subparagraph (a)2. may not exclude
 864 benefits based on a preexisting condition if the individual has
 865 a continuous period of creditable coverage, as defined in s.
 866 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
 867 application for coverage.

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

870 (c) If a Medicare supplement policy or certificate
 871 replaces another Medicare supplement policy or certificate or
 872 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
 873 the replacing insurer shall waive any time periods applicable to
 874 preexisting conditions, waiting periods, elimination periods,
 875 and probationary periods in the new Medicare supplement policy
 876 for similar benefits to the extent such time was spent under the
 877 original policy, ~~subject to the requirements of s. 627.6561(6)~~
 878 ~~(11)~~.

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

881 641.31 Health maintenance contracts.—

882 (2) The rates charged by any health maintenance
 883 organization to its subscribers shall not be excessive,
 884 inadequate, or unfairly discriminatory or follow a rating

885 methodology that is inconsistent, indeterminate, or ambiguous or
886 encourages misrepresentation or misunderstanding. ~~A law~~
887 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
888 ~~annual or lifetime maximum payments shall not apply to any~~
889 ~~health maintenance organization contract that provides coverage~~
890 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
891 ~~individual or a group of 51 or more persons.~~ The commission, in
892 accordance with generally accepted actuarial practice as applied
893 to health maintenance organizations, may define by rule what
894 constitutes excessive, inadequate, or unfairly discriminatory
895 rates and may require whatever information it deems necessary to
896 determine that a rate or proposed rate meets the requirements of
897 this subsection.

898 (40)(a) Any group rate, rating schedule, or rating manual
899 for a health maintenance organization policy, which provides
900 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
901 filed with the office shall provide for an appropriate rebate of
902 premiums paid in the last policy year, contract year, or
903 calendar year when the majority of members of a health plan are
904 enrolled in and have maintained participation in any health
905 wellness, maintenance, or improvement program offered by the
906 group contract holder. The group must provide evidence of
907 demonstrative maintenance or improvement of his or her health
908 status as determined by assessments of agreed-upon health status
909 indicators between the group and the health insurer, including,
910 but not limited to, reduction in weight, body mass index, and

911 smoking cessation. Any rebate provided by the health maintenance
 912 organization is presumed to be appropriate unless credible data
 913 demonstrates otherwise, or unless the rebate program requires
 914 the insured to incur costs to qualify for the rebate which
 915 equals or exceeds the value of the rebate but the rebate may not
 916 exceed 10 percent of paid premiums.

917 Section 22. Section 641.31071, Florida Statutes, is
 918 amended to read:

919 641.31071 Preexisting conditions.—

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

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

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

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

931 2. A special enrollment period, as provided under s.
 932 641.31072.

933 (c) "Waiting period" means, with respect to a group health
 934 maintenance organization contract and an individual who is a
 935 potential participant or beneficiary under the contract, the
 936 period that must pass with respect to the individual before the

937 individual is eligible to be covered for benefits under the
938 terms of the contract.

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

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

948 (b) Such exclusion extends for a period of not more than
949 12 months, or 18 months in the case of a late enrollee, after
950 the enrollment date; and

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

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

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

962 1. An individual who, as of the last day of the 30-day

963 period beginning with the date of birth, is covered under
964 creditable coverage.

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

971 3. Pregnancy.

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

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

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

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

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

989 ~~Act.~~

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

991 ~~coverage consisting solely of benefits under s. 1928.~~

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

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

994 ~~of a tribal organization.~~

995 ~~7. The Florida Comprehensive Health Association or another~~

996 ~~state health benefit risk pool.~~

997 ~~8. A health plan offered under chapter 89 of Title 5,~~

998 ~~United States Code.~~

999 ~~9. A public health plan as defined by rule of the~~

1000 ~~commission. To the greatest extent possible, such rules must be~~

1001 ~~consistent with regulations adopted by the United States~~

1002 ~~Department of Health and Human Services.~~

1003 ~~10. A health benefit plan under s. 5(c) of the Peace Corps~~

1004 ~~Act (22 U.S.C. s. 2504(e)).~~

1005 ~~(b) Creditable coverage does not include coverage that~~

1006 ~~consists solely of one or more or any combination thereof of the~~

1007 ~~following excepted benefits:~~

1008 ~~1. Coverage only for accident, or disability income~~

1009 ~~insurance, or any combination thereof.~~

1010 ~~2. Coverage issued as a supplement to liability insurance.~~

1011 ~~3. Liability insurance, including general liability~~

1012 ~~insurance and automobile liability insurance.~~

1013 ~~4. Workers' compensation or similar insurance.~~

1014 ~~5. Automobile medical payment insurance.~~

1015 ~~6. Credit-only insurance.~~

1016 ~~7. Coverage for onsite medical clinics.~~

1017 ~~8. Other similar insurance coverage, specified in rules~~
 1018 ~~adopted by the commission, under which benefits for medical care~~
 1019 ~~are secondary or incidental to other insurance benefits. To the~~
 1020 ~~greatest extent possible, such rules must be consistent with~~
 1021 ~~regulations adopted by the United States Department of Health~~
 1022 ~~and Human Services.~~

1023 ~~(c) The following benefits are not subject to the~~
 1024 ~~creditable coverage requirements, if offered separately;~~

1025 ~~1. Limited scope dental or vision benefits.~~

1026 ~~2. Benefits or long-term care, nursing home care, home~~
 1027 ~~health care, community-based care, or any combination of these.~~

1028 ~~3. Such other similar, limited benefits as are specified~~
 1029 ~~in rules adopted by the commission. To the greatest extent~~
 1030 ~~possible, such rules must be consistent with regulations adopted~~
 1031 ~~by the United States Department of Health and Human Services.~~

1032 ~~(d) The following benefits are not subject to creditable~~
 1033 ~~coverage requirements if offered as independent, noncoordinated~~
 1034 ~~benefits:~~

1035 ~~1. Coverage only for a specified disease or illness.~~

1036 ~~2. Hospital indemnity or other fixed indemnity insurance.~~

1037 ~~(e) Benefits provided through Medicare supplemental health~~
 1038 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
 1039 ~~Act, coverage supplemental to the coverage provided under~~
 1040 ~~chapter 55 of Title 10, United States Code, and similar~~

1041 ~~supplemental coverage provided to coverage under a group health~~
1042 ~~plan are not considered creditable coverage if offered as a~~
1043 ~~separate insurance policy.~~

1044 ~~(6)(a) A period of creditable coverage may not be counted,~~
1045 ~~with respect to enrollment of an individual under a group health~~
1046 ~~maintenance organization contract, if, after such period and~~
1047 ~~before the enrollment date, there was a 63-day period during all~~
1048 ~~of which the individual was not covered under any creditable~~
1049 ~~coverage.~~

1050 ~~(b) Any period during which an individual is in a waiting~~
1051 ~~period, or in an affiliation period as defined in subsection~~
1052 ~~(9), for any coverage under a group health maintenance~~
1053 ~~organization contract may not be taken into account in~~
1054 ~~determining the 63-day period under paragraph (a) or paragraph~~
1055 ~~(4)(b).~~

1056 ~~(7)(a) Except as otherwise provided under paragraph (b), a~~
1057 ~~health maintenance organization shall count a period of~~
1058 ~~creditable coverage without regard to the specific benefits~~
1059 ~~covered under the period.~~

1060 ~~(b) A health maintenance organization may elect to count~~
1061 ~~as creditable coverage, coverage of benefits within each of~~
1062 ~~several classes or categories of benefits specified in rules~~
1063 ~~adopted by the commission rather than as provided under~~
1064 ~~paragraph (a). Such election shall be made on a uniform basis~~
1065 ~~for all participants and beneficiaries. Under such election, a~~
1066 ~~health maintenance organization shall count a period of~~

1067 ~~creditable coverage with respect to any class or category of~~
1068 ~~benefits if any level of benefits is covered within such class~~
1069 ~~or category.~~

1070 ~~(c) In the case of an election with respect to a health~~
1071 ~~maintenance organization under paragraph (b), the organization~~
1072 ~~shall:~~

1073 ~~1. Prominently state in 10-point type or larger in any~~
1074 ~~disclosure statements concerning the contract, and state to each~~
1075 ~~enrollee at the time of enrollment under the contract, that the~~
1076 ~~organization has made such election; and~~

1077 ~~2. Include in such statements a description of the effect~~
1078 ~~of this election.~~

1079 ~~(8)(a) Periods of creditable coverage with respect to an~~
1080 ~~individual shall be established through presentation of~~
1081 ~~certifications described in this subsection or in such other~~
1082 ~~manner as may be specified in rules adopted by the commission.~~

1083 ~~(b) A health maintenance organization that offers group~~
1084 ~~coverage shall provide the certification described in paragraph~~
1085 ~~(a):~~

1086 ~~1. At the time an individual ceases to be covered under~~
1087 ~~the plan or otherwise becomes covered under a COBRA continuation~~
1088 ~~provision or continuation pursuant to s. 627.6692.~~

1089 ~~2. In the case of an individual becoming covered under a~~
1090 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
1091 ~~time the individual ceases to be covered under such a provision.~~

1092 ~~3. Upon the request on behalf of an individual made not~~

1093 ~~later than 24 months after the date of cessation of the coverage~~
 1094 ~~described in this paragraph.~~

1095
 1096 ~~The certification under subparagraph 1. may be provided, to the~~
 1097 ~~extent practicable, at a time consistent with notices required~~
 1098 ~~under any applicable COBRA continuation provision or~~
 1099 ~~continuation pursuant to s. 627.6692.~~

1100 ~~(c) The certification is a written certification of:~~

1101 ~~1. The period of creditable coverage of the individual~~
 1102 ~~under the contract and the coverage, if any, under such COBRA~~
 1103 ~~continuation provision or continuation pursuant to s. 627.6692;~~
 1104 ~~and~~

1105 ~~2. The waiting period, if any, imposed with respect to the~~
 1106 ~~individual for any coverage under such contract.~~

1107 ~~(d) In the case of an election described in subsection (7)~~
 1108 ~~by a health maintenance organization, if the organization~~
 1109 ~~enrolls an individual for coverage under the plan and the~~
 1110 ~~individual provides a certification of coverage of the~~
 1111 ~~individual, as provided by this subsection:~~

1112 ~~1. Upon request of such health maintenance organization,~~
 1113 ~~the insurer or health maintenance organization that issued the~~
 1114 ~~certification provided by the individual shall promptly disclose~~
 1115 ~~to such requesting organization information on coverage of~~
 1116 ~~classes and categories of health benefits available under such~~
 1117 ~~insurer's or health maintenance organization's plan or coverage.~~

1118 ~~2. Such insurer or health maintenance organization may~~

1119 ~~charge the requesting organization for the reasonable cost of~~
1120 ~~disclosing such information.~~

1121 ~~(c) The commission shall adopt rules to prevent an~~
1122 ~~insurer's or health maintenance organization's failure to~~
1123 ~~provide information under this subsection with respect to~~
1124 ~~previous coverage of an individual from adversely affecting any~~
1125 ~~subsequent coverage of the individual under another group health~~
1126 ~~plan or health maintenance organization coverage.~~

1127 ~~(9) (a) A health maintenance organization may provide for~~
1128 ~~an affiliation period with respect to coverage through the~~
1129 ~~organization only if:~~

1130 ~~1. No preexisting condition exclusion is imposed with~~
1131 ~~respect to coverage through the organization;~~

1132 ~~2. The period is applied uniformly without regard to any~~
1133 ~~health status related factors; and~~

1134 ~~3. Such period does not exceed 2 months or 3 months in the~~
1135 ~~case of a late enrollee.~~

1136 ~~(b) For the purposes of this section, the term~~
1137 ~~"affiliation period" means a period that, under the terms of the~~
1138 ~~coverage offered by the health maintenance organization, must~~
1139 ~~expire before the coverage becomes effective. The organization~~
1140 ~~is not required to provide health care services or benefits~~
1141 ~~during such period, and no premium may be charged to the~~
1142 ~~participant or beneficiary for any coverage during the period.~~
1143 ~~Such period begins on the enrollment date and runs concurrently~~
1144 ~~with any waiting period under the plan.~~

1145 ~~(c) As an alternative to the method authorized by~~
1146 ~~paragraph (a), a health maintenance organization may address~~
1147 ~~adverse selection in a method approved by the office.~~

1148 ~~(10) (a) Except as provided in paragraph (b), no period~~
1149 ~~before July 1, 1996, shall be taken into account in determining~~
1150 ~~creditable coverage.~~

1151 ~~(b) The commission shall adopt rules that provide a~~
1152 ~~process whereby individuals who need to establish creditable~~
1153 ~~coverage for periods before July 1, 1996, and who would have~~
1154 ~~such coverage credited but for paragraph (a), may be given~~
1155 ~~credit for creditable coverage for such periods through the~~
1156 ~~presentation of documents or other means.~~

1157 ~~(11) Except as otherwise provided in this subsection, the~~
1158 ~~requirements of paragraph (8) (b) shall apply to events that~~
1159 ~~occur on or after July 1, 1996.~~

1160 ~~(a) In no case is a certification required to be provided~~
1161 ~~under paragraph (8) (b) prior to June 1, 1997.~~

1162 ~~(b) In the case of an event that occurs on or after July~~
1163 ~~1, 1996, and before October 1, 1996, a certification is not~~
1164 ~~required to be provided under paragraph (8) (b), unless an~~
1165 ~~individual, with respect to whom the certification is required~~
1166 ~~to be made, requests such certification in writing.~~

1167 ~~(12) In the case of an individual who seeks to establish~~
1168 ~~creditable coverage for any period for which certification is~~
1169 ~~not required because it relates to an event occurring before~~
1170 ~~July 1, 1996:~~

1171 ~~(a) The individual may present other creditable coverage~~
1172 ~~in order to establish the period of creditable coverage.~~

1173 ~~(b) A health maintenance organization is not subject to~~
1174 ~~any penalty or enforcement action with respect to the~~
1175 ~~organization's crediting, or not crediting, such coverage if the~~
1176 ~~organization has sought to comply in good faith with applicable~~
1177 ~~provisions of this section.~~

1178 ~~(13) For purposes of subsection (10), any plan amendment~~
1179 ~~made pursuant to a collective bargaining agreement relating to~~
1180 ~~the plan which amends the plan solely to conform to any~~
1181 ~~requirement of this section may not be treated as a termination~~
1182 ~~of such collective bargaining agreement.~~

1183 Section 23. Subsections (1), (3), and (4) of section
1184 641.31074, Florida Statutes, are amended to read:

1185 641.31074 Guaranteed renewability of coverage.—

1186 (1) Except as otherwise provided in this section, a health
1187 maintenance organization that issues a ~~group~~ health insurance
1188 contract must renew or continue in force such coverage at the
1189 option of the contract holder.

1190 (3) (a) A health maintenance organization may discontinue
1191 offering a particular contract form ~~for group coverage offered~~
1192 ~~in the small group market or large group market~~ only if:

1193 1. The health maintenance organization provides notice to
1194 each contract holder provided coverage of this form in such
1195 market, and participants and beneficiaries covered under such
1196 coverage, of such discontinuation at least 90 days prior to the

1197 date of the nonrenewal of such coverage;

1198 2. The health maintenance organization offers to each
 1199 contract holder provided coverage of this form in such market
 1200 the option to purchase all, or in the case of the large group
 1201 market, any other health insurance coverage currently being
 1202 offered by the health maintenance organization in such market;
 1203 and

1204 3. In exercising the option to discontinue coverage of
 1205 this form and in offering the option of coverage under
 1206 subparagraph 2., the health maintenance organization acts
 1207 uniformly without regard to the claims experience of those
 1208 contract holders or any health-status-related factor that
 1209 relates to any participants or beneficiaries covered or new
 1210 participants or beneficiaries who may become eligible for such
 1211 coverage.

1212 (b)1. In any case in which a health maintenance
 1213 organization elects to discontinue offering all coverage in the
 1214 individual market, small group market, or the large group
 1215 market, or any combination thereof ~~both~~, in this state, coverage
 1216 may be discontinued by the insurer only if:

1217 a. The health maintenance organization provides notice to
 1218 the office and to each contract holder, and participants and
 1219 beneficiaries covered under such coverage, of such
 1220 discontinuation at least 180 days prior to the date of the
 1221 nonrenewal of such coverage; and

1222 b. All health insurance issued or delivered for issuance

1223 in this state in such market is discontinued and coverage under
 1224 such health insurance coverage in such market is not renewed.

1225 2. In the case of a discontinuation under subparagraph 1.
 1226 in a market, the health maintenance organization may not provide
 1227 for the issuance of any health maintenance organization contract
 1228 coverage in the market in this state during the 5-year period
 1229 beginning on the date of the discontinuation of the last
 1230 insurance contract not renewed.

1231 (4) At the time of coverage renewal, a health maintenance
 1232 organization may modify the coverage for a product offered:

1233 (a) In the large group market; or

1234 (b) In the small group market if, for coverage that is
 1235 available in such market other than only through one or more
 1236 bona fide associations, as defined in s. 627.6571(5), such
 1237 modification is consistent with s. 627.6699 and effective on a
 1238 uniform basis among group health plans with that product; or

1239 (c) In the individual market if the modification is
 1240 consistent with the laws of this state and effective on a
 1241 uniform basis among all individuals with that policy form.

1242 Section 24. Section 641.312, Florida Statutes, is amended
 1243 to read:

1244 641.312 Scope.—The Office of Insurance Regulation may
 1245 adopt rules to administer the provisions of the National
 1246 Association of Insurance Commissioners' Uniform Health Carrier
 1247 External Review Model Act, issued by the National Association of
 1248 Insurance Commissioners and dated April 2010. This section does

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1249 | not apply to a health maintenance contract that is subject to
1250 | the Subscriber Assistance Program under s. 408.7056 or to the
1251 | types of benefits or coverages provided under s. 627.6513(1)-
1252 | (14) ~~627.6561(5)(b)-(e)~~ issued in any market.
1253 | Section 25. This act shall take effect July 1, 2016.