



220604

LEGISLATIVE ACTION

Senate

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House

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Floor: 1/AD/2R

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04/24/2019 11:42 AM

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Senator Simpson moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Effective July 1, 2019, paragraph (b) of
subsection (1) of section 624.438, Florida Statutes, is amended
to read:

624.438 General eligibility.—

(1) To meet the requirements for issuance of a certificate
of authority and to maintain a multiple-employer welfare
arrangement, an arrangement:



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12 (b)~~1~~. Must be established by a bona fide group ~~trade~~
13 ~~association, industry association, or professional~~ association
14 of employers as defined in 29 C.F.R. s. 2510.3-5 ~~or~~
15 ~~professionals~~ which has a constitution or bylaws specifically
16 stating its purpose and which has been organized ~~and maintained~~
17 ~~in good faith for a continuous period of 1 year~~ for purposes in
18 addition to other than that of obtaining or providing insurance.

19 ~~2. Must not combine member employers from disparate trades,~~
20 ~~industries, or professions as defined by the appropriate~~
21 ~~licensing agencies, and must not combine member employers from~~
22 ~~more than one of the employer categories defined in sub-~~
23 ~~subparagraphs a.-c.~~

24 ~~a. A trade association consists of member employers who are~~
25 ~~in the same trade as recognized by the appropriate licensing~~
26 ~~agency.~~

27 ~~b. An industry association consists of member employers who~~
28 ~~are in the same major group code, as defined by the Standard~~
29 ~~Industrial Classification Manual issued by the federal Office of~~
30 ~~Management and Budget, unless restricted by sub-subparagraph a.~~
31 ~~or sub-subparagraph c.~~

32 ~~e. A professional association consists of member employers~~
33 ~~who are of the same profession as recognized by the appropriate~~
34 ~~licensing agency.~~

35
36 The requirements of this paragraph ~~subparagraph~~ do not apply to
37 an arrangement licensed before ~~prior to~~ April 1, 1995,
38 regardless of the nature of its business. However, an
39 arrangement exempt from the requirements of this paragraph
40 ~~subparagraph~~ may not expand the nature of its business beyond



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41 that set forth in the articles of incorporation of its
42 sponsoring association as of April 1, 1995, except as authorized
43 in this paragraph ~~subparagraph~~.

44 Section 2. Section 627.443, Florida Statutes, is created to
45 read:

46 627.443 Essential health benefits.—

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

48 (a) "EHB-benchmark plan" has the same meaning as provided
49 in 45 C.F.R. s. 156.20.

50 (b) "PPACA" has the same meaning as in s. 627.402.

51 (2) A health insurer or health maintenance organization
52 issuing or delivering an individual or a group health insurance
53 policy or health maintenance contract in this state may create a
54 new health insurance policy or health maintenance contract that:

55 (a) Must include at least one service or coverage under
56 each of the 10 essential health benefits categories under 42
57 U.S.C. s. 18022(b) which are required under PPACA;

58 (b) May fulfill the requirement in paragraph (a) by
59 selecting one or more services or coverages for each of the
60 required categories from the list of essential health benefits
61 required by any single state or multiple states; and

62 (c) May comply with paragraphs (a) and (b) by selecting one
63 or more services or coverages from any one or more of the
64 required categories of essential health benefits from one state
65 or multiple states.

66 (3) This section specifically authorizes an insurer or
67 health maintenance organization to include any combination of
68 services or coverages required by any one or a combination of
69 states to provide the 10 categories of essential health benefits



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70 required under PPACA in a policy or contract issued in this
71 state.

72 (4) Health insurance policies and health maintenance
73 contracts created by health insurers and health maintenance
74 organizations under this section:

75 (a) May be submitted to the office for consideration as
76 part of the office's study of this state's essential health
77 benefits benchmark plan; and

78 (b) May also be submitted to the office for evaluation as
79 equivalent to the current state EHB-benchmark plan or to any
80 EHB-benchmark plan created in the future.

81 Section 3. Effective July 1, 2019, subsection (3) of
82 section 627.6045, Florida Statutes, is amended to read:

83 627.6045 Preexisting condition.—A health insurance policy
84 must comply with the following:

85 (3) This section does not apply to short-term, ~~nonrenewable~~
86 ~~health insurance policies of no more than a 6-month policy term,~~
87 provided that it is clearly disclosed to the applicant in the
88 advertising and application, in 14-point ~~10-point~~ contrasting
89 type, that "This policy does not meet the definition of
90 qualifying previous coverage or qualifying existing coverage as
91 defined in s. 627.6699. As a result, if purchased in lieu of a
92 conversion policy or other group coverage, you may have to meet
93 a preexisting condition requirement when renewing or purchasing
94 other coverage."

95 Section 4. Effective July 1, 2019, section 627.6046,
96 Florida Statutes, is created to read:

97 627.6046 Limit on preexisting conditions.—

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



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99 (a) "Operative date" means the date on which either of the
100 following occurs with respect to the Patient Protection and
101 Affordable Care Act, Pub. L. No. 111-148, as amended by the
102 Health Care and Education Reconciliation Act of 2010, Pub. L.
103 No. 111-152 (PPACA):

104 1. A federal law is enacted which expressly repeals PPACA;
105 or

106 2. PPACA is invalidated by the United States Supreme Court.

107 (b) "Preexisting medical condition" means a condition that
108 was present before the effective date of coverage under a
109 policy, whether or not any medical advice, diagnosis, care, or
110 treatment was recommended or received before the effective date
111 of coverage. The term includes a condition identified as a
112 result of a preenrollment questionnaire or physical examination
113 given to the individual, or review of medical records relating
114 to the preenrollment period.

115 (2) (a) Not later than 30 days after the operative date, and
116 notwithstanding s. 627.6045 or any other law to the contrary,
117 every insurer issuing, delivering, or issuing for delivery
118 comprehensive major medical individual health insurance policies
119 in this state shall make at least one comprehensive major
120 medical health insurance policy available to all residents of
121 this state, and such insurer may not exclude, limit, deny, or
122 delay coverage under such policy due to one or more preexisting
123 medical conditions.

124 (b) An insurer may not limit or exclude benefits under such
125 policy, including a denial of coverage applicable to an
126 individual as a result of information relating to an
127 individual's health status before the individual's effective



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128 date of coverage, or if coverage is denied, the date of the
129 denial.

130 (3) The comprehensive major medical health insurance policy
131 that the insurer is required to offer under this section must be
132 a policy that had been actively marketed in this state by the
133 insurer as of the operative date and that was also actively
134 marketed in this state during the year immediately preceding the
135 operative date.

136 (4) This section does not apply to an insurer that issues
137 only limited benefit, disability income, specified disease,
138 Medicare supplement, or hospital indemnity policies in this
139 state.

140 Section 5. Effective July 1, 2019, subsection (1) of
141 section 627.6425, Florida Statutes, is amended to read:

142 627.6425 Renewability of individual coverage.—

143 (1) Except as otherwise provided in this section, an
144 insurer that provides individual health insurance coverage to an
145 individual shall renew or continue in force such coverage at the
146 option of the individual. For the purpose of this section, the
147 term "individual health insurance" means health insurance
148 coverage, as described in s. 624.603, offered to an individual
149 in this state, including certificates of coverage offered to
150 individuals in this state as part of a group policy issued to an
151 association outside this state, but the term does not include
152 ~~short-term limited duration insurance or~~ excepted benefits
153 specified in s. 627.6513(1)-(14).

154 Section 6. Effective July 1, 2019, section 627.6426,
155 Florida Statutes, is created to read:

156 627.6426 Short-term health insurance.—



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157 (1) For purposes of this part, the term "short-term health
158 insurance" means health insurance coverage provided by an issuer
159 with an expiration date specified in the contract which is less
160 than 12 months after the original effective date of the contract
161 and, taking into account renewals or extensions, has a duration
162 not to exceed 36 months in total.

163 (2) All contracts for short-term health insurance entered
164 into by an issuer and an individual seeking coverage shall
165 include the following disclosure:

166
167 "This coverage is not required to comply with certain federal
168 market requirements for health insurance, principally those
169 contained in the Patient Protection and Affordable Care Act. Be
170 sure to check your policy carefully to make sure you are aware
171 of any exclusions or limitations regarding coverage of
172 preexisting conditions or health benefits (such as
173 hospitalization, emergency services, maternity care, preventive
174 care, prescription drugs, and mental health and substance use
175 disorder services). Your policy might also have lifetime and/or
176 annual dollar limits on health benefits. If this coverage
177 expires or you lose eligibility for this coverage, you might
178 have to wait until an open enrollment period to get other health
179 insurance coverage."

180 Section 7. Effective July 1, 2019, section 627.6525,
181 Florida Statutes, is created to read:

182 627.6525 Short-term health insurance.-

183 (1) For purposes of this part, the term "short-term health
184 insurance" means a group, blanket, or franchise policy of health
185 insurance coverage provided by an issuer with an expiration date



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186 specified in the contract which is less than 12 months after the
187 original effective date of the contract and, taking into account
188 renewals or extensions, has a duration not to exceed 36 months
189 in total.

190 (2) All contracts for short-term health insurance entered
191 into by an issuer and a party seeking coverage shall include the
192 following disclosure:

193
194 "This coverage is not required to comply with certain federal
195 market requirements for health insurance, principally those
196 contained in the Patient Protection and Affordable Care Act. Be
197 sure to check your policy carefully to make sure you are aware
198 of any exclusions or limitations regarding coverage of
199 preexisting conditions or health benefits (such as
200 hospitalization, emergency services, maternity care, preventive
201 care, prescription drugs, and mental health and substance use
202 disorder services). Your policy might also have lifetime and/or
203 annual dollar limits on health benefits. If this coverage
204 expires or you lose eligibility for this coverage, you might
205 have to wait until an open enrollment period to get other health
206 insurance coverage."

207 Section 8. Effective July 1, 2019, subsection (1) of
208 section 627.654, Florida Statutes, is amended to read:

209 627.654 Labor union, association, and small employer health
210 alliance groups.-

211 (1) (a) A bona fide group or association of employers, as
212 defined in 29 C.F.R. s. 2510.3-5, or a group of individuals may
213 be insured under a policy issued to an association, including a
214 labor union, which association has a constitution and bylaws and



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215 ~~not less than 25 individual members~~ and which has been organized
216 ~~and has been maintained in good faith for a period of 1 year for~~
217 ~~purposes in addition to other than that of~~ obtaining insurance,
218 or to the trustees of a fund established by such an association,
219 which association or trustees shall be deemed the policyholder,
220 insuring at least 15 individual members of the association for
221 the benefit of persons other than the officers of the
222 association, the association, or trustees.

223 (b) A small employer, as defined in s. 627.6699 and
224 including the employer's eligible employees and the spouses and
225 dependents of such employees, may be insured under a policy
226 issued to a small employer health alliance by a carrier as
227 defined in s. 627.6699. ~~A small employer health alliance must be~~
228 ~~organized as a not-for-profit corporation under chapter 617.~~
229 ~~Notwithstanding any other law, if a small employer member of an~~
230 ~~alliance loses eligibility to purchase health care through the~~
231 ~~alliance solely because the business of the small employer~~
232 ~~member expands to more than 50 and fewer than 75 eligible~~
233 ~~employees, the small employer member may, at its next renewal~~
234 ~~date, purchase coverage through the alliance for not more than 1~~
235 ~~additional year. A small employer health alliance shall~~
236 ~~establish conditions of participation in the alliance by a small~~
237 ~~employer, including, but not limited to:~~

238 1. ~~Assurance that the small employer is not formed for the~~
239 ~~purpose of securing health benefit coverage.~~

240 2. ~~Assurance that the employees of a small employer have~~
241 ~~not been added for the purpose of securing health benefit~~
242 ~~coverage.~~

243 Section 9. Effective July 1, 2019, section 627.65612,



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244 Florida Statutes, is created to read:

245 627.65612 Limit on preexisting conditions.-

246 (1) As used in this section, the terms "operative date" and
247 "preexisting medical condition" have the same meanings as
248 provided in s. 627.6046.

249 (2) (a) Not later than 30 days after the operative date, and
250 notwithstanding s. 627.6561 or any other law to the contrary,
251 every insurer issuing, delivering, or issuing for delivery
252 comprehensive major medical group health insurance policies in
253 this state shall make at least one comprehensive major medical
254 health insurance policy available to all residents of this
255 state, and such insurer may not exclude, limit, deny, or delay
256 coverage under such policy due to one or more preexisting
257 medical conditions.

258 (b) An insurer may not limit or exclude benefits under such
259 policy, including a denial of coverage applicable to an
260 individual as a result of information relating to an
261 individual's health status before the individual's effective
262 date of coverage, or if coverage is denied, the date of the
263 denial.

264 (3) The comprehensive major medical health insurance policy
265 that the insurer is required to offer under this section must be
266 a policy that had been actively marketed in this state by the
267 insurer as of the operative date and that was also actively
268 marketed in this state during the year immediately preceding the
269 operative date.

270 (4) This section does not apply to an insurer issuing only
271 limited benefit, disability income, specified disease, Medicare
272 supplement, or hospital indemnity policies in this state.



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273 Section 10. Effective July 1, 2019, subsection (45) is
274 added to section 641.31, Florida Statutes, to read:

275 641.31 Health maintenance contracts.—

276 (45) (a) As used in this subsection, the terms "operative
277 date" and "preexisting medical condition" have the same meanings
278 as provided in s. 627.6046.

279 (b) Not later than 30 days after the operative date, and
280 notwithstanding s. 641.31071 or any other law to the contrary,
281 every health maintenance organization issuing, delivering, or
282 issuing for delivery individual or group contracts in this state
283 shall make at least one comprehensive major medical health
284 maintenance contract available to all residents of this state,
285 and such health maintenance organization may not exclude, limit,
286 deny, or delay coverage under such contract due to one or more
287 preexisting medical conditions. A health maintenance
288 organization may not limit or exclude benefits under such
289 contract, including a denial of coverage applicable to an
290 individual as a result of information relating to an
291 individual's health status before the individual's effective
292 date of coverage, or if coverage is denied, the date of the
293 denial.

294 (c) The comprehensive major medical health maintenance
295 contract the health maintenance organization is required to
296 offer under this section must be a contract that had been
297 actively marketed in this state by the health maintenance
298 organization as of the operative date and that was also actively
299 marketed in this state during the year immediately preceding the
300 operative date.

301 Section 11. Study of state essential health benefits



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302 benchmark plan; report.-

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

304 (a) "EHB-benchmark plan" has the same meaning as provided
305 in 45 C.F.R. s. 156.20.

306 (b) "Office" means the Office of Insurance Regulation.

307 (2) The office shall conduct a study to evaluate this
308 state's current EHB-benchmark plan for nongrandfathered
309 individual and group health plans and options for changing the
310 EHB-benchmark plan pursuant to 45 C.F.R. s. 156.111 for future
311 plan years. In conducting the study, the office shall:

312 (a) Consider EHB-benchmark plans and benefits under the 10
313 essential health benefits categories established under 45 C.F.R.
314 s. 156.110(a) which are used by the other 49 states;

315 (b) Compare the costs of benefits within such categories
316 and overall costs of EHB-benchmark plans used by other states
317 with the costs of benefits within the categories and overall
318 costs of the current EHB-benchmark plan of this state; and

319 (c) Solicit and consider proposed individual and group
320 health plans from health insurers and health maintenance
321 organizations in developing recommendations for changes to the
322 current EHB-benchmark plan.

323 (3) By October 30, 2019, the office shall submit a report
324 to the Governor, the President of the Senate, and the Speaker of
325 the House of Representatives which must include recommendations
326 for changing the current EHB-benchmark plan to provide
327 comprehensive care at a lower cost than this state's current
328 EHB-benchmark plan. In its report, the office shall provide an
329 analysis as to whether proposed health plans it receives under
330 paragraph (2) (c) meet the requirements for an EHB-benchmark plan



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331 under 45 C.F.R. s. 156.111(b).

332 Section 12. If any provision of this act or its application
333 to any person or circumstance is held invalid, the invalidity
334 does not affect other provisions or applications of the act
335 which can be given effect without the invalid provision or
336 application, and to this end the provisions of this act are
337 severable.

338 Section 13. Except as otherwise expressly provided in this
339 act, this act shall take effect upon becoming a law.

340

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

342 And the title is amended as follows:

343 Delete everything before the enacting clause
344 and insert:

345 A bill to be entitled
346 An act relating to health plans; amending s. 624.438,
347 F.S.; revising eligibility requirements for multiple-
348 employer welfare arrangements; creating s. 627.443,
349 F.S.; defining the terms "EHB-benchmark plan" and
350 "PPACA"; authorizing health insurers and health
351 maintenance organizations to create new health
352 insurance policies and health maintenance contracts
353 meeting certain criteria for essential health benefits
354 under the federal Patient Protection and Affordable
355 Care Act (PPACA); providing that such criteria may be
356 met by certain means; providing construction;
357 providing that such policies and contracts created by
358 health insurers and health maintenance organizations
359 may be submitted to the Office of Insurance Regulation



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360 for certain purposes; amending s. 627.6045, F.S.;

361 revising applicability of requirements relating to

362 preexisting conditions; revising the font size for a

363 certain disclosure; creating s. 627.6046, F.S.;

364 defining the terms "operative date" and "preexisting

365 medical condition" with respect to individual health

366 insurance policies; requiring certain insurers,

367 contingent upon the occurrence of either of two

368 specified events, to make at least one comprehensive

369 major medical health insurance policy available to all

370 residents of this state within a specified timeframe;

371 prohibiting such insurers from excluding, limiting,

372 denying, or delaying coverage under such policies due

373 to preexisting medical conditions; requiring such

374 policies to have been actively marketed on a specified

375 date and during a certain timeframe before that date;

376 providing applicability; amending s. 627.6425, F.S.;

377 revising the definition of the term "individual health

378 insurance" relating to renewability of individual

379 coverage; creating ss. 627.6426 and 627.6525, F.S.;

380 defining the term "short-term health insurance";

381 providing disclosure requirements for short-term

382 individual, group, blanket, and franchise health

383 insurance policies; amending s. 627.654, F.S.;

384 revising requirements for, and applicability relating

385 to, association and small employer policies; creating

386 s. 627.65612, F.S.; defining the terms "operative

387 date" and "preexisting medical condition" with respect

388 to group health insurance policies; requiring certain



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389 insurers, contingent upon the occurrence of either of
390 two specified events, to make at least one
391 comprehensive major medical health insurance policy
392 available to all residents of this state within a
393 specified timeframe; prohibiting such insurers from
394 excluding, limiting, denying, or delaying coverage
395 under such policies due to preexisting medical
396 conditions; requiring such policies to have been
397 actively marketed on a specified date and during a
398 certain timeframe before that date; providing
399 applicability; amending s. 641.31, F.S.; defining the
400 terms "operative date" and "preexisting medical
401 condition" with respect to health maintenance
402 contracts; requiring health maintenance organizations,
403 contingent upon the occurrence of either of two
404 specified events, to make at least one comprehensive
405 major medical health maintenance contract available to
406 all residents of this state within a specified
407 timeframe; prohibiting such health maintenance
408 organizations from excluding, limiting, denying, or
409 delaying coverage under such contracts due to
410 preexisting medical conditions; requiring such
411 contracts to have been actively marketed on a
412 specified date and during a certain timeframe before
413 that date; defining the terms "EHB-benchmark plan" and
414 "office"; requiring the office to conduct a study
415 evaluating this state's current benchmark plan for
416 essential health benefits under PPACA and options for
417 changing the benchmark plan for future plan years;



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418 requiring the office, in conducting the study, to
419 consider plans and certain benefits used by other
420 states and to compare costs with those of this state;
421 requiring the office to solicit and consider proposed
422 health plans from health insurers and health
423 maintenance organizations in developing
424 recommendations; requiring the office, by a certain
425 date, to provide a report with certain recommendations
426 and a certain analysis to the Governor and the
427 Legislature; providing for severability; providing
428 effective dates.