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1 A bill to be entitled
2 An act relating to health plans; amending s. 624.438,
3 F.S.; revising eligibility requirements for multiple-
4 employer welfare arrangements; creating s. 627.443,
5 F.S.; defining the terms "EHB-benchmark plan" and
6 "PPACA"; authorizing health insurers and health
7 maintenance organizations to create new health
8 insurance policies and health maintenance contracts
9 meeting certain criteria for essential health benefits
10 under the federal Patient Protection and Affordable
11 Care Act (PPACA); providing that such criteria may be
12 met by certain means; providing construction;
13 providing that such policies and contracts created by
14 health insurers and health maintenance organizations
15 may be submitted to the Office of Insurance Regulation
16 for certain purposes; amending s. 627.6045, F.S.;
17 revising applicability; revising font size for
18 disclosure; creating ss. 627.6046 and 627.65612, F.S.;
19 defining the terms "operative date" and "preexisting
20 medical condition" with respect to individual and
21 group health insurance policies, respectively;
22 requiring insurers, contingent upon the occurrence of
23 either of two specified events, to make at least one
24 comprehensive major medical health insurance policy
25 available to certain individuals within a specified
26 timeframe; prohibiting such insurers from excluding,
27 limiting, denying, or delaying coverage under such
28 policy due to preexisting medical conditions;
29 requiring such policy to have been actively marketed

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30 on a specified date and during a certain timeframe
31 before that date; providing applicability; creating
32 ss. 627.6426 and 627.6525, F.S.; defining the term
33 "short-term health insurance"; providing disclosure
34 requirements for short-term health insurance policies;
35 amending s. 627.654, F.S.; revising requirements for
36 association and small employer policies; providing
37 construction; amending s. 641.31, F.S.; defining the
38 terms "operative date" and "preexisting medical
39 condition" with respect to health maintenance
40 contracts; requiring health maintenance organizations,
41 contingent upon the occurrence of either of two
42 specified events, to make at least one comprehensive
43 major medical health maintenance contract available to
44 certain individuals within a specified timeframe;
45 prohibiting such health maintenance organizations from
46 excluding, limiting, denying, or delaying coverage
47 under such contract due to preexisting medical
48 conditions; requiring such contract to have been
49 actively marketed on a specified date and during a
50 certain timeframe before that date; defining the terms
51 "EHB-benchmark plan" and "office"; requiring the
52 office to conduct a study evaluating this state's
53 current benchmark plan for essential health benefits
54 under PPACA and options for changing the benchmark
55 plan for future plan years; requiring the office, in
56 conducting the study, to consider plans and certain
57 benefits used by other states and to compare costs
58 with those of this state; requiring the office to

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59 solicit and consider proposed health plans from health
60 insurers and health maintenance organizations in
61 developing recommendations; requiring the office, by a
62 certain date, to provide a report with certain
63 recommendations and a certain analysis to the Governor
64 and the Legislature; providing for severability;
65 providing an effective date.

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

68
69 Section 1. Paragraph (b) of subsection (1) of section
70 624.438, Florida Statutes, is amended to read:

71 624.438 General eligibility.—

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

75 (b)~~1~~. Must be established by a trade association, industry
76 association, ~~or~~ professional association of employers or
77 professionals, or a bona fide group as defined in 29 C.F.R. part
78 2510.3-5 which has a constitution or bylaws specifically stating
79 its purpose and which has been organized ~~and maintained in good~~
80 ~~faith for a continuous period of 1 year~~ for purposes in addition
81 to ~~other than that of~~ obtaining or providing insurance.

82 ~~2. Must not combine member employers from disparate trades,~~
83 ~~industries, or professions as defined by the appropriate~~
84 ~~licensing agencies, and must not combine member employers from~~
85 ~~more than one of the employer categories defined in sub-~~
86 ~~subparagraphs a.-c.~~

87 1.a. A trade association consists of member employers who

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88 are in the same trade as recognized by the appropriate licensing
89 agency.

90 ~~2.b.~~ An industry association consists of member employers
91 who are in the same major group code, as defined by the Standard
92 Industrial Classification Manual issued by the federal Office of
93 Management and Budget, unless restricted by subparagraph 1. ~~sub-~~
94 ~~subparagraph a.~~ or subparagraph 3 ~~sub-subparagraph e.~~

95 ~~3.e.~~ A professional association consists of member
96 employers who are of the same profession as recognized by the
97 appropriate licensing agency.

98
99 The requirements of this paragraph ~~subparagraph~~ do not apply to
100 an arrangement licensed before ~~prior to~~ April 1, 1995,
101 regardless of the nature of its business. However, an
102 arrangement exempt from the requirements of this paragraph
103 ~~subparagraph~~ may not expand the nature of its business beyond
104 that set forth in the articles of incorporation of its
105 sponsoring association as of April 1, 1995, except as authorized
106 in this paragraph ~~subparagraph~~.

107 Section 2. Section 627.443, Florida Statutes, is created to
108 read:

109 627.443 Essential health benefits.—

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

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

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

114 (2) A health insurer or health maintenance organization
115 issuing or delivering an individual or a group health insurance
116 policy or health maintenance contract in this state may create a

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117 new health insurance policy or health maintenance contract that:

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

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

125 (c) May comply with paragraphs (a) and (b) by selecting one
126 or more services or coverages from any one or more of the
127 required categories of essential health benefits from one state
128 or multiple states.

129 (3) This section specifically authorizes an insurer or
130 health maintenance organization to include any combination of
131 services or coverages required by any one or a combination of
132 states to provide the 10 categories of essential health benefits
133 required under PPACA in a policy or contract issued in this
134 state.

135 (4) Health insurance policies and health maintenance
136 contracts created by health insurers and health maintenance
137 organizations under this section:

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

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

144 Section 3. Subsection (3) of section 627.6045, Florida
145 Statutes, is amended to read:

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146 627.6045 Preexisting condition.—A health insurance policy
147 must comply with the following:

148 (3) This section does not apply to short-term,~~nonrenewable~~
149 health insurance ~~policies of no more than a 6-month policy term,~~
150 provided that it is clearly disclosed to the applicant in the
151 advertising and application, in 14-point ~~10-point~~ contrasting
152 type, that “This policy does not meet the definition of
153 qualifying previous coverage or qualifying existing coverage as
154 defined in s. 627.6699. As a result, if purchased in lieu of a
155 conversion policy or other group coverage, you may have to meet
156 a preexisting condition requirement when renewing or purchasing
157 other coverage.”

158 Section 4. Section 627.6046, Florida Statutes, is created
159 to read:

160 627.6046 Limit on preexisting conditions.—

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

162 (a) “Operative date” means the date on which either of the
163 following occurs with respect to the Patient Protection and
164 Affordable Care Act, Pub. L. No. 111-148, as amended by the
165 Health Care and Education Reconciliation Act of 2010, Pub. L.
166 No. 111-152 (PPACA):

167 1. A federal law is enacted which expressly repeals PPACA;

168 or

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

170 (b) “Preexisting medical condition” means a condition that
171 was present before the effective date of coverage under a
172 policy, whether or not any medical advice, diagnosis, care, or
173 treatment was recommended or received before the effective date
174 of coverage. The term includes a condition identified as a

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175 result of a preenrollment questionnaire or physical examination
176 given to the individual, or review of medical records relating
177 to the preenrollment period.

178 (2) (a) Not later than 30 days after the operative date, and
179 notwithstanding s. 627.6045 or any other law to the contrary,
180 every insurer issuing, delivering, or issuing for delivery
181 comprehensive major medical individual health insurance policies
182 in this state shall make at least one comprehensive major
183 medical health insurance policy available to residents in the
184 insurer's approved service areas of this state, and such insurer
185 may not exclude, limit, deny, or delay coverage under such
186 policy due to one or more preexisting medical conditions.

187 (b) An insurer may not limit or exclude benefits under such
188 policy, including a denial of coverage applicable to an
189 individual as a result of information relating to an
190 individual's health status before the individual's effective
191 date of coverage, or if coverage is denied, the date of the
192 denial.

193 (3) The comprehensive major medical health insurance policy
194 that the insurer is required to offer under this section must be
195 a policy that had been actively marketed in this state by the
196 insurer as of the operative date and that was also actively
197 marketed in this state during the year immediately preceding the
198 operative date.

199 Section 5. Section 627.6426, Florida Statutes, is created
200 to read:

201 627.6426 Short-term health insurance.-

202 (1) For purposes of this part, the term "short-term health
203 insurance" means health insurance coverage provided by an issuer

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204 with an expiration date specified in the contract that is less
205 than 12 months after the original effective date of the contract
206 and, taking into account renewals or extensions, has a duration
207 not to exceed 36 months in total.

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

211
212 "This coverage is not required to comply with certain federal
213 market requirements for health insurance, principally those
214 contained in the Patient Protection and Affordable Care Act. Be
215 sure to check your policy carefully to make sure you are aware
216 of any exclusions or limitations regarding coverage of
217 preexisting conditions or health benefits (such as
218 hospitalization, emergency services, maternity care, preventive
219 care, prescription drugs, and mental health and substance use
220 disorder services). Your policy might also have lifetime and/or
221 annual dollar limits on health benefits. If this coverage
222 expires or you lose eligibility for this coverage, you might
223 have to wait until an open enrollment period to get other health
224 insurance coverage."

225 Section 6. Section 627.6525, Florida Statutes, is created
226 to read:

227 627.6525 Short-term health insurance.-

228 (1) For purposes of this part, the term "short-term health
229 insurance" means a group, blanket, or franchise policy of health
230 insurance coverage provided by an issuer with an expiration date
231 specified in the contract that is less than 12 months after the
232 original effective date of the contract and, taking into account

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233 renewals or extensions, has a duration not to exceed 36 months
234 in total.

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

238
239 "This coverage is not required to comply with certain federal
240 market requirements for health insurance, principally those
241 contained in the Patient Protection and Affordable Care Act. Be
242 sure to check your policy carefully to make sure you are aware
243 of any exclusions or limitations regarding coverage of
244 preexisting conditions or health benefits (such as
245 hospitalization, emergency services, maternity care, preventive
246 care, prescription drugs, and mental health and substance use
247 disorder services). Your policy might also have lifetime and/or
248 annual dollar limits on health benefits. If this coverage
249 expires or you lose eligibility for this coverage, you might
250 have to wait until an open enrollment period to get other health
251 insurance coverage."

252 Section 7. Subsection (1) of section 627.654, Florida
253 Statutes, is amended to read:

254 627.654 Labor union, association, and small employer health
255 alliance groups.—

256 (1) (a) A bona fide group or association of employers, as
257 defined in 29 C.F.R. part 2510.3-5, or a group of individuals
258 may be insured under a policy issued to an association,
259 including a labor union, which association has a constitution
260 and bylaws ~~and not less than 25 individual members~~ and which has
261 been organized ~~and has been maintained in good faith for a~~

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262 ~~period of 1 year~~ for purposes in addition to ~~other than~~ that of
263 obtaining insurance, or to the trustees of a fund established by
264 such an association, which association or trustees shall be
265 deemed the policyholder, insuring at least 15 individual members
266 of the association for the benefit of persons other than the
267 officers of the association, the association, or trustees.

268 (b) A small employer, as defined in s. 627.6699 and
269 including the employer's eligible employees and the spouses and
270 dependents of such employees, may be insured under a policy
271 issued to a small employer health alliance by a carrier as
272 defined in s. 627.6699. ~~A small employer health alliance must be~~
273 ~~organized as a not-for-profit corporation under chapter 617.~~
274 ~~Notwithstanding any other law, if a small employer member of an~~
275 ~~alliance loses eligibility to purchase health care through the~~
276 ~~alliance solely because the business of the small employer~~
277 ~~member expands to more than 50 and fewer than 75 eligible~~
278 ~~employees, the small employer member may, at its next renewal~~
279 ~~date, purchase coverage through the alliance for not more than 1~~
280 ~~additional year. A small employer health alliance shall~~
281 ~~establish conditions of participation in the alliance by a small~~
282 ~~employer, including, but not limited to:~~

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

285 ~~2. Assurance that the employees of a small employer have~~
286 ~~not been added for the purpose of securing health benefit~~
287 ~~coverage.~~

288 Section 8. Section 627.65612, Florida Statutes, is created
289 to read:

290 627.65612 Limit on preexisting conditions.-

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

294 (2) (a) Not later than 30 days after the operative date, and
295 notwithstanding s. 627.6561 or any other law to the contrary,
296 every insurer issuing, delivering, or issuing for delivery
297 comprehensive major medical group health insurance policies in
298 this state shall make at least one comprehensive major medical
299 health insurance policy available to residents in the insurer's
300 approved service areas of this state, and such insurer may not
301 exclude, limit, deny, or delay coverage under such policy due to
302 one or more preexisting medical conditions.

303 (b) An insurer may not limit or exclude benefits under such
304 policy, including a denial of coverage applicable to an
305 individual as a result of information relating to an
306 individual's health status before the individual's effective
307 date of coverage, or if coverage is denied, the date of the
308 denial.

309 (3) The comprehensive major medical health insurance policy
310 that the insurer is required to offer under this section must be
311 a policy that had been actively marketed in this state by the
312 insurer as of the operative date and that was also actively
313 marketed in this state during the year immediately preceding the
314 operative date.

315 Section 9. Subsection (45) is added to section 641.31,
316 Florida Statutes, to read:

317 641.31 Health maintenance contracts.—

318 (45) (a) As used in this subsection, the terms "operative
319 date" and "preexisting medical condition" have the same meanings

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320 as provided in s. 627.6046.

321 (b) Not later than 30 days after the operative date, and
322 notwithstanding s. 641.31071 or any other law to the contrary,
323 every health maintenance organization issuing, delivering, or
324 issuing for delivery comprehensive major medical individual or
325 group contracts in this state shall make at least one
326 comprehensive major medical health maintenance contract
327 available to residents in the health maintenance organization's
328 approved service areas of this state, and such health
329 maintenance organization may not exclude, limit, deny, or delay
330 coverage under such contract due to one or more preexisting
331 medical conditions. A health maintenance organization may not
332 limit or exclude benefits under such contract, including a
333 denial of coverage applicable to an individual as a result of
334 information relating to an individual's health status before the
335 individual's effective date of coverage, or if coverage is
336 denied, the date of the denial.

337 (c) The comprehensive major medical health maintenance
338 contract the health maintenance organization is required to
339 offer under this section must be a contract that had been
340 actively marketed in this state by the health maintenance
341 organization as of the operative date and that was also actively
342 marketed in this state during the year immediately preceding the
343 operative date.

344 Section 10. Study of state essential health benefits
345 benchmark plan; report.-

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

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

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

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

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

358 (b) Compare the costs of benefits within such categories
359 and overall costs of EHB-benchmark plans used by other states
360 with the costs of benefits within the categories and overall
361 costs of the current EHB-benchmark plan of this state; and

362 (c) Solicit and consider proposed individual and group
363 health plans from health insurers and health maintenance
364 organizations in developing recommendations for changes to the
365 current EHB-benchmark plan.

366 (3) By October 30, 2019, the office shall submit a report
367 to the Governor, the President of the Senate, and the Speaker of
368 the House of Representatives which must include recommendations
369 for changing the current EHB-benchmark plan to provide
370 comprehensive care at a lower cost than this state's current
371 EHB-benchmark plan. In its report, the office shall provide an
372 analysis as to whether proposed health plans it receives under
373 paragraph (2) (c) meet the requirements for an EHB-benchmark plan
374 under 45 C.F.R. s. 156.111(b).

375 Section 11. If any provision of this act or its application
376 to any person or circumstance is held invalid, the invalidity
377 does not affect other provisions or applications of the act

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378 which can be given effect without the invalid provision or
379 application, and to this end the provisions of this act are
380 severable.

381 Section 12. This act shall take effect upon becoming a law.