A bill to be entitled

An act relating to health plans; amending s. 624.438, F.S.; revising eligibility requirements for multiple-employer welfare arrangements; creating s. 627.443, F.S.; providing definitions; specifying conditions under which health insurers and health maintenance organizations may comply with requirements under the federal Patient Protection and Affordable Care Act to provide essential health benefits; amending s. 627.6045, F.S.; revising applicability; revising font size for disclosure; creating ss. 627.6046 and 627.65612, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to individual and group health insurance policies, respectively; requiring insurers, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health insurance policy available to certain individuals within a specified timeframe; prohibiting such insurers from excluding, limiting, denying, or delaying coverage under such policies due to preexisting medical conditions; requiring such policies to have been actively marketed on a specified date and during a certain timeframe before that date; providing applicability; creating ss. 627.6426 and

627.6525, F.S.; defining the term "short-term health insurance"; providing disclosure requirements for short-term health insurance policies; amending s. 627.654, F.S.; revising requirements for association and small employer policies; providing construction; amending s. 641.31, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to health maintenance contracts; requiring health maintenance organizations, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health maintenance contract available to certain individuals within a specified timeframe; prohibiting such health maintenance organizations from excluding, limiting, denying, or delaying coverage under such contracts due to preexisting medical conditions; requiring such contracts to have been actively marketed on a specified date and during a certain timeframe before that date; requiring the Office of Insurance Regulation to conduct a study evaluating the current state essential health benefits benchmark plan under the federal Patient Protection and Affordable Care Act; providing an effective date.

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

Section 1. 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:

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

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

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

2.~~b.~~ An industry association consists of member employers who are in the same major group code, as defined by the Standard Industrial Classification Manual issued by the federal Office of

Management and Budget, unless restricted by subparagraph 1. ~~sub-subparagraph a.~~ or subparagraph 3 ~~sub-subparagraph c~~.

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

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

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

627.443 Essential health benefits.—

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

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

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

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

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

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

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

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

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

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

(b) May be submitted to the office for evaluation as equivalent to the current state EHB-benchmark plan or to any

EHB-benchmark plan created in the future.

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

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

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

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

627.6046 Limit on preexisting conditions.—

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

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

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

or

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

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

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

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

denial.

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

(4) This section does not apply to an insurer that issues only limited benefit, disability income, short-term health insurance, specified disease, Medicare supplement, or hospital indemnity policies in this state.

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

627.6426 Short-term health insurance.—

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

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

"This coverage is not required to comply with certain federal

market requirements for health insurance, principally those contained in the Patient Protection and Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

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

627.6525 Short-term health insurance.—

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

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

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

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

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

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

obtaining insurance, or to the trustees of a fund established by such an association, which association or trustees shall be deemed the policyholder, insuring at least 15 individual members of the association for the benefit of persons other than the officers of the association, the association, or trustees.

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

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

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

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

627.65612 Limit on preexisting conditions.—

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

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

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

(3) The comprehensive major medical health insurance policy that the insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also

actively marketed in this state during the year immediately preceding the operative date.

(4) This section does not apply to an insurer issuing only limited benefit, disability income, short-term health insurance, specified disease, Medicare supplement, or hospital indemnity policies in this state.

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

641.31 Health maintenance contracts.—

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

(b) Not later than 30 days after the operative date, and notwithstanding s. 641.31071 or any other law to the contrary, every health maintenance organization issuing, delivering, or issuing for delivery individual or group contracts in this state shall make at least one comprehensive major medical health maintenance contract available to residents in the organization's approved service areas of this state, and such health maintenance organization may not exclude, limit, deny, or delay coverage under such contract due to one or more preexisting medical conditions. A health maintenance organization may not limit or exclude benefits under such contract, including a denial of coverage applicable to an individual as a result of information relating to an

individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

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

Section 10. Study of state essential health benefits benchmark plan; report.—

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

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

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

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

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

(b) Compare the costs of benefits within such categories

and overall costs of EHB-benchmark plans used by other states with the costs of benefits within the categories and overall costs of the current EHB-benchmark plan of this state; and

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

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

(4) Health plans created by health insurers and health maintenance organizations under this section:

(a) May be submitted to the office for consideration as part of the study under this section; and

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

Section 11. This act shall take effect upon becoming a law.