By the Committee on Banking and Insurance; and Senator Detert

597-02615-16 20161170c1

1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 408.909, F.S.; redefining
4 the term "health care coverage" or "health flex plan
5 coverage"; amending s. 409.817, F.S.; deleting a
6 provision authorizing group insurance plans to impose
7 a certain preexisting condition exclusion; amending s.
8 624.123, F.S.; conforming a cross-reference; amending
9 s. 627.402, F.S.; redefining the term
10 "nongrandfathered health plan"; amending s. 627.411,
11 F.S.; deleting a provision relating to a minimum loss
12 ratio standard for specified health insurance
13 coverage; deleting provisions specifying certain
14 incurred claims; amending s. 627.6011, F.S.,
15 conforming a cross-reference; amending s. 627.602,
16 F.S.; conforming a cross-reference; amending s.
17 627.642, F.S.; revising the policies to which certain
18 outline of coverage requirements apply; amending s.
19 627.6425, F.S.; redefining the term "individual health
20 insurance"; revising applicability; amending s.
21 627.6487, F.S.; redefining terms; repealing s.
22 627.64871, F.S., relating to certification of
23 coverage; amending s. 627.6512, F.S.; revising a
24 provision specifying that certain sections of the
25 Florida Insurance Code do not apply to a group health
26 insurance policy as that policy relates to specified
27 benefits, under certain circumstances; amending s.
28 627.6513, F.S.; excluding applicability as to certain
29 types of benefits or coverages; repealing s. 627.6561,
30 F.S., relating to preexisting conditions; amending s.
31 627.6562, F.S.; redefining the term "creditable
32 coverage"; providing exceptions and applicability;

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33 amending s. 627.65626, F.S.; conforming a cross-
34 reference; amending s. 627.6699, F.S.; redefining
35 terms; deleting a provision that requires a certain
36 health benefit plan to comply with specified
37 preexisting condition provisions; conforming
38 provisions to changes made by the act; amending s.
39 627.6741, F.S.; conforming cross-references;
40 conforming a provision to changes made by the act;
41 amending s. 641.185, F.S.; revising certain standards
42 to remove requirements for a health maintenance
43 organization to provide specified coverage for
44 preexisting conditions; conforming provisions to
45 changes made by the act; amending s. 641.31, F.S.;
46 deleting a provision specifying that a law restricting
47 or limiting deductibles, coinsurance, copayments, or
48 annual or lifetime maximum payments may not apply to a
49 certain health maintenance organization contract;
50 conforming a cross-reference; repealing s. 641.31071,
51 F.S., relating to preexisting conditions; amending s.
52 641.3111, F.S.; deleting a provision specifying that a
53 subscriber is not entitled to an extension of benefits
54 under certain circumstances after termination of a
55 group health maintenance contract; amending s.
56 641.312, F.S.; conforming a cross-reference; providing
57 an effective date.
58
59 Be It Enacted by the Legislature of the State of Florida:
60
61 Section 1. Paragraph (d) of subsection (2) of section

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62 408.909, Florida Statutes, is amended to read:
63 408.909 Health flex plans.—
64 (2) DEFINITIONS.—As used in this section, the term:
65 (d) “Health care coverage” or “health flex plan coverage”
66 means health care services that are covered as benefits under an
67 approved health flex plan or that are otherwise provided, either
68 directly or through arrangements with other persons, via a
69 health flex plan on a prepaid per capita basis or on a prepaid
70 aggregate fixed-sum basis. The terms may also include one or
71 more of the excepted benefits under s. 627.6513(1)-(13) ~~s.~~
72 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
73 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
74 ~~as independent, noncoordinated benefits~~.
75 Section 2. Section 409.817, Florida Statutes, is amended to
76 read:
77 409.817 Approval of health benefits coverage; financial
78 assistance.—In order for health insurance coverage to qualify
79 for premium assistance payments for an eligible child under ss.
80 409.810-409.821, the health benefits coverage must:
81 (1) Be certified by the Office of Insurance Regulation of
82 the Financial Services Commission under s. 409.818 as meeting,
83 exceeding, or being actuarially equivalent to the benchmark
84 benefit plan;
85 (2) Be guarantee issued;
86 (3) Be community rated;
87 (4) Not impose any preexisting condition exclusion for
88 covered benefits; ~~however, group health insurance plans may~~
89 ~~permit the imposition of a preexisting condition exclusion, but~~
90 ~~only insofar as it is permitted under s. 627.6561;~~

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91 (5) Comply with the applicable limitations on premiums and
92 cost sharing in s. 409.816;
93 (6) Comply with the quality assurance and access standards
94 developed under s. 409.820; and
95 (7) Establish periodic open enrollment periods, which may
96 not occur more frequently than quarterly.
97 Section 3. Paragraph (b) of subsection (1) of section
98 624.123, Florida Statutes, is amended to read:
99 624.123 Certain international health insurance policies;
100 exemption from code.—
101 (1) International health insurance policies and
102 applications may be solicited and sold in this state at any
103 international airport to a resident of a foreign country. Such
104 international health insurance policies shall be solicited and
105 sold only by a licensed health insurance agent and underwritten
106 only by an admitted insurer. For purposes of this subsection:
107 (b) "International health insurance policy" means health
108 insurance, as <u>provided</u> ~~defined~~ in <u>s. 627.6562(3)(a)2.</u> ~~s.~~
109 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
110 only a resident of a foreign country on an annual basis.
111 Section 4. Subsection (2) of section 627.402, Florida
112 Statutes, is amended to read:
113 627.402 Definitions.—As used in this part, the term:
114 (2) "Nongrandfathered health plan" is a health insurance
115 policy or health maintenance organization contract that is not a
116 grandfathered health plan and does not provide the benefits or
117 coverages specified under <u>s. 627.6513(1)-(14)</u> ~~s. 627.6561(5)(b)-~~
118 ~~(e)~~.
119 Section 5. Subsection (3) of section 627.411, Florida

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120 Statutes, is amended to read:
121 627.411 Grounds for disapproval.—
122 ~~(3)(a) For health insurance coverage as described in s.~~
123 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
124 ~~claims to earned premium for the form shall be 65 percent.~~
125 ~~(b) Incurred claims are claims occurring within a fixed~~
126 ~~period, whether or not paid during the same period, under the~~
127 ~~terms of the policy period.~~
128 ~~1. Claims include scheduled benefit payments or services~~
129 ~~provided by a provider or through a provider network for dental,~~
130 ~~vision, disability, and similar health benefits.~~
131 ~~2. Claims do not include state assessments, taxes, company~~
132 ~~expenses, or any expense incurred by the company for the cost of~~
133 ~~adjusting and settling a claim, including the review,~~
134 ~~qualification, oversight, management, or monitoring of a claim~~
135 ~~or incentives or compensation to providers for other than the~~
136 ~~provisions of health care services.~~
137 ~~3. A company may at its discretion include costs that are~~
138 ~~demonstrated to reduce claims, such as fraud intervention~~
139 ~~programs or case management costs, which are identified in each~~
140 ~~filing, are demonstrated to reduce claims costs, and do not~~
141 ~~result in increasing the experience period loss ratio by more~~
142 ~~than 5 percent.~~
143 ~~4. For scheduled claim payments, such as disability income~~
144 ~~or long-term care, the incurred claims shall be the present~~
145 ~~value of the benefit payments discounted for continuance and~~
146 ~~interest.~~
147 Section 6. Section 627.6011, Florida Statutes, is amended
148 to read:

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

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

627.602 Scope, format of policy.—

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

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

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

627.642 Outline of coverage.—

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

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178 (a) It is accompanied by an appropriate outline of
179 coverage; or
180 (b) An appropriate outline of coverage is completed and
181 delivered to the applicant at the time application is made, and
182 an acknowledgment of receipt or certificate of delivery of such
183 outline is provided to the insurer with the application.
184
185 In the case of a direct response, such as a written application
186 to the insurance company from an applicant, the outline of
187 coverage shall accompany the policy when issued.
188 Section 9. Subsections (1), (6), and (7) of section
189 627.6425, Florida Statutes, are amended, to read:
190 627.6425 Renewability of individual coverage.—
191 (1) Except as otherwise provided in this section, an
192 insurer that provides individual health insurance coverage to an
193 individual shall renew or continue in force such coverage at the
194 option of the individual. For the purpose of this section, the
195 term “individual health insurance” means health insurance
196 coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~,
197 offered to an individual in this state, including certificates
198 of coverage offered to individuals in this state as part of a
199 group policy issued to an association outside this state, but
200 the term does not include short-term limited duration insurance
201 or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
202 ~~(6) or subsection (7)~~.
203 ~~(6) The requirements of this section do not apply to any~~
204 ~~health insurance coverage in relation to its provision of~~
205 ~~excepted benefits described in s. 627.6561(5)(b).~~
206 ~~(7) The requirements of this section do not apply to any~~

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207 ~~health insurance coverage in relation to its provision of~~
208 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~
209 ~~if the benefits are provided under a separate policy,~~
210 ~~certificate, or contract of insurance.~~
211 Section 10. Paragraph (b) of subsection (2) and subsection
212 (3) of section 627.6487, Florida Statutes, are amended to read:
213 627.6487 Guaranteed availability of individual health
214 insurance coverage to eligible individuals.—
215 (2) For the purposes of this section:
216 (b) “Individual health insurance” means health insurance,
217 as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered
218 to an individual, including certificates of coverage offered to
219 individuals in this state as part of a group policy issued to an
220 association outside this state, but the term does not include
221 short-term limited duration insurance or excepted benefits
222 specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the~~
223 ~~benefits are provided under a separate policy, certificate, or~~
224 ~~contract, the term does not include excepted benefits specified~~
225 ~~in s. 627.6561(5)(c), (d), or (e)~~.
226 (3) For the purposes of this section, the term “eligible
227 individual” means an individual:
228 (a)1. For whom, as of the date on which the individual
229 seeks coverage under this section, the aggregate of the periods
230 of creditable coverage, as defined in s. 627.6562(3) ~~s.~~
231 ~~627.6561(5) and (6)~~, is 18 or more months; and
232 2.a. Whose most recent prior creditable coverage was under
233 a group health plan, governmental plan, or church plan, or
234 health insurance coverage offered in connection with any such
235 plan; or

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236 b. Whose most recent prior creditable coverage was under an
237 individual plan issued in this state by a health insurer or
238 health maintenance organization, which coverage is terminated
239 due to the insurer or health maintenance organization becoming
240 insolvent or discontinuing the offering of all individual
241 coverage in the State of Florida, or due to the insured no
242 longer living in the service area in the State of Florida of the
243 insurer or health maintenance organization that provides
244 coverage through a network plan in the State of Florida;
245 (b) Who is not eligible for coverage under:
246 1. A group health plan, as defined in s. 2791 of the Public
247 Health Service Act;
248 2. A conversion policy or contract issued by an authorized
249 insurer or health maintenance organization under s. 627.6675 or
250 s. 641.3921, respectively, offered to an individual who is no
251 longer eligible for coverage under either an insured or self-
252 insured employer plan;
253 3. Part A or part B of Title XVIII of the Social Security
254 Act; or
255 4. A state plan under Title XIX of such act, or any
256 successor program, and does not have other health insurance
257 coverage;
258 (c) With respect to whom the most recent coverage within
259 the coverage period described in paragraph (a) was not
260 terminated based on a factor described in s. 627.6571(2)(a) or
261 (b), relating to nonpayment of premiums or fraud, unless such
262 nonpayment of premiums or fraud was due to acts of an employer
263 or person other than the individual;
264 (d) Who, having been offered the option of continuation

265 coverage under a COBRA continuation provision or under s.
266 627.6692, elected such coverage; and
267 (e) Who, if the individual elected such continuation
268 provision, has exhausted such continuation coverage under such
269 provision or program.
270 Section 11. Section 627.64871, Florida Statutes, is
271 repealed.
272 Section 12. Section 627.6512, Florida Statutes, is amended
273 to read:
274 627.6512 Exemption of certain group health insurance
275 policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571
276 do not apply to~~:~~
277 ~~(1)~~ any group insurance policy in relation to its provision
278 of ~~excepted~~ benefits described in s. 627.6513(1)-(14) ~~s.~~
279 ~~627.6561(5)(b)~~.
280 ~~(2) Any group health insurance policy in relation to its~~
281 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
282 ~~if the benefits:~~
283 ~~(a) Are provided under a separate policy, certificate, or~~
284 ~~contract of insurance; or~~
285 ~~(b) Are otherwise not an integral part of the policy.~~
286 ~~(3) Any group health insurance policy in relation to its~~
287 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
288 ~~if all of the following conditions are met:~~
289 ~~(a) The benefits are provided under a separate policy,~~
290 ~~certificate, or contract of insurance;~~
291 ~~(b) There is no coordination between the provision of such~~
292 ~~benefits and any exclusion of benefits under any group policy~~
293 ~~maintained by the same policyholder; and~~

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294 ~~(c) Such benefits are paid with respect to an event without~~
295 ~~regard to whether benefits are provided with respect to such an~~
296 ~~event under any group health policy maintained by the same~~
297 ~~policyholder.~~
298 ~~(4) Any group health policy in relation to its provision of~~
299 ~~excepted benefits described in s. 627.6561(5)(c), if the~~
300 ~~benefits are provided under a separate policy, certificate, or~~
301 ~~contract of insurance.~~
302 Section 13. Section 627.6513, Florida Statutes, is amended
303 to read:
304 627.6513 Scope.—Section 641.312 and the provisions of the
305 Employee Retirement Income Security Act of 1974, as implemented
306 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
307 apply to all group health insurance policies issued under this
308 part. This section does not apply to a group health insurance
309 policy that is subject to the Subscriber Assistance Program in
310 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
311 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
312 (1) Coverage only for accident insurance or disability
313 income insurance, or any combination thereof.
314 (2) Coverage issued as a supplement to liability insurance.
315 (3) Liability insurance, including general liability
316 insurance and automobile liability insurance.
317 (4) Workers' compensation or similar insurance.
318 (5) Automobile medical payment insurance.
319 (6) Credit-only insurance.
320 (7) Coverage for onsite medical clinics, including prepaid
321 health clinics under part II of chapter 641.
322 (8) Other similar insurance coverage, specified in rules

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323 adopted by the commission, under which benefits for medical care
324 are secondary or incidental to other insurance benefits. To the
325 extent possible, such rules must be consistent with regulations
326 adopted by the United States Department of Health and Human
327 Services.
328 (9) Limited scope dental or vision benefits, if offered
329 separately.
330 (10) Benefits for long-term care, nursing home care, home
331 health care, or community-based care, or any combination
332 thereof, if offered separately.
333 (11) Other similar limited benefits, if offered separately,
334 as specified in rules adopted by the commission.
335 (12) Coverage only for a specified disease or illness, if
336 offered as independent, noncoordinated benefits.
337 (13) Hospital indemnity or other fixed indemnity insurance,
338 if offered as independent, noncoordinated benefits.
339 (14) Benefits provided through a Medicare supplemental
340 health insurance policy, as defined under s. 1882(g)(1) of the
341 Social Security Act, coverage supplemental to the coverage
342 provided under 10 U.S.C. chapter 55, and similar supplemental
343 coverage provided to coverage under a group health plan, which
344 are offered as a separate insurance policy and as independent,
345 noncoordinated benefits.
346 Section 14. Section 627.6561, Florida Statutes, is
347 repealed.
348 Section 15. Subsection (3) of section 627.6562, Florida
349 Statutes, is amended to read:
350 627.6562 Dependent coverage.—
351 (3) If, pursuant to subsection (2), a child is provided

352 coverage under the parent’s policy after the end of the calendar
353 year in which the child reaches age 25 and coverage for the
354 child is subsequently terminated, the child is not eligible to
355 be covered under the parent’s policy unless the child was
356 continuously covered by other creditable coverage without a gap
357 in coverage of more than 63 days.
358 (a) For the purposes of this subsection, the term
359 “creditable coverage” means, with respect to an individual,
360 coverage of the individual under any of the following: ~~has the~~
361 ~~same meaning as provided in s. 627.6561(5).~~
362 1. A group health plan, as defined in s. 2791 of the Public
363 Health Service Act.
364 2. Health insurance coverage consisting of medical care
365 provided directly through insurance or reimbursement or
366 otherwise, and including terms and services paid for as medical
367 care, under any hospital or medical service policy or
368 certificate, hospital or medical service plan contract, or
369 health maintenance contract offered by a health insurance
370 issuer.
371 3. Part A or part B of Title XVIII of the Social Security
372 Act.
373 4. Title XIX of the Social Security Act, other than
374 coverage consisting solely of benefits under s. 1928.
375 5. 10 U.S.C. chapter 55.
376 6. A medical care program of the Indian Health Service or
377 of a tribal organization.
378 7. The Florida Comprehensive Health Association or another
379 state health benefit risk pool.
380 8. A health plan offered under 5 U.S.C. chapter 89.

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381 9. A public health plan as defined by rules adopted by the
382 commission. To the greatest extent possible, such rules must be
383 consistent with regulations adopted by the United States
384 Department of Health and Human Services.
385 10. A health benefit plan under s. 5(e) of the Peace Corps
386 Act, 22 U.S.C. s. 2504(e).
387 (b) Creditable coverage does not include coverage that
388 consists of one or more, or any combination thereof, of the
389 following excepted benefits:
390 1. Coverage only for accident insurance or disability
391 income insurance, or any combination thereof.
392 2. Coverage issued as a supplement to liability insurance.
393 3. Liability insurance, including general liability
394 insurance and automobile liability insurance.
395 4. Workers' compensation or similar insurance.
396 5. Automobile medical payment insurance.
397 6. Credit-only insurance.
398 7. Coverage for onsite medical clinics, including prepaid
399 health clinics under part II of chapter 641.
400 8. Other similar insurance coverage specified in rules
401 adopted by the commission under which benefits for medical care
402 are secondary or incidental to other insurance benefits. To the
403 extent possible, such rules must be consistent with regulations
404 adopted by the United States Department of Health and Human
405 Services.
406 (c) The following benefits are not subject to the
407 creditable coverage requirements, if offered separately:
408 1. Limited scope dental or vision benefits.
409 2. Benefits for long-term care, nursing home care, home

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410 health care, or community-based care, or any combination
411 thereof.
412 3. Other similar, limited benefits specified in rules
413 adopted by the commission.
414 (d) The following benefits are not subject to creditable
415 coverage requirements if offered as independent, noncoordinated
416 benefits:
417 1. Coverage only for a specified disease or illness.
418 2. Hospital indemnity or other fixed indemnity insurance.
419 (e) Benefits provided through a Medicare supplemental
420 health insurance policy, as defined under s. 1882(g)(1) of the
421 Social Security Act, coverage supplemental to the coverage
422 provided under 10 U.S.C. chapter 55, and similar supplemental
423 coverage provided to coverage under a group health plan are not
424 considered creditable coverage if offered as a separate
425 insurance policy.
426 Section 16. Subsection (1) of section 627.65626, Florida
427 Statutes, is amended to read:
428 627.65626 Insurance rebates for healthy lifestyles.—
429 (1) Any rate, rating schedule, or rating manual for a
430 health insurance policy that provides creditable coverage as
431 defined in s. 627.6562(3) ~~s. 627.6561(5)~~ filed with the office
432 shall provide for an appropriate rebate of premiums paid in the
433 last policy year, contract year, or calendar year when the
434 majority of members of a health plan have enrolled and
435 maintained participation in any health wellness, maintenance, or
436 improvement program offered by the group policyholder and health
437 plan. The rebate may be based upon premiums paid in the last
438 calendar year or policy year. The group must provide evidence of

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439 demonstrative maintenance or improvement of the enrollees’
440 health status as determined by assessments of agreed-upon health
441 status indicators between the policyholder and the health
442 insurer, including, but not limited to, reduction in weight,
443 body mass index, and smoking cessation. The group or health
444 insurer may contract with a third-party administrator to
445 assemble and report the health status required in this
446 subsection between the policyholder and the health insurer. Any
447 rebate provided by the health insurer is presumed to be
448 appropriate unless credible data demonstrates otherwise, or
449 unless the rebate program requires the insured to incur costs to
450 qualify for the rebate which equal or exceed the value of the
451 rebate, but the rebate may not exceed 10 percent of paid
452 premiums.
453 Section 17. Paragraphs (e), (l), and (n) of subsection (3),
454 paragraphs (c) and (d) of subsection (5), and paragraph (b) of
455 subsection (6) of section 627.6699, Florida Statutes, are
456 amended to read:
457 627.6699 Employee Health Care Access Act.—
458 (3) DEFINITIONS.—As used in this section, the term:
459 (e) “Creditable coverage” has the same meaning ascribed in
460 s. 627.6562(3) ~~s. 627.6561~~.
461 (l) “Late enrollee” means an eligible employee or dependent
462 who, with respect to coverage under a group health policy, is a
463 participant or beneficiary who enrolls under the policy other
464 than during:
465 1. The first period in which the individual is eligible to
466 enroll under the policy.
467 2. A special enrollment period, as provided under s.

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468 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
469 (n) "Modified community rating" means a method used to
470 develop carrier premiums which spreads financial risk across a
471 large population; allows the use of separate rating factors for
472 age, gender, family composition, tobacco usage, and geographic
473 area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows
474 adjustments for~~:~~ claims experience, health status, or duration
475 of coverage as permitted under subparagraph (6)(b)5.; and
476 administrative and acquisition expenses as permitted under
477 subparagraph (6)(b)5.
478 (5) AVAILABILITY OF COVERAGE.—
479 ~~(c) Except as provided in paragraph (d), a health benefit~~
480 ~~plan covering small employers must comply with preexisting~~
481 ~~condition provisions specified in s. 627.6561 or, for health~~
482 ~~maintenance contracts, in s. 641.31071.~~
483 (c)~~(d)~~ A health benefit plan covering small employers,
484 issued or renewed on or after January 1, 1994, must comply with
485 the following conditions:
486 1. All health benefit plans must be offered and issued on a
487 guaranteed-issue basis. Additional or increased benefits may
488 only be offered by riders.
489 ~~2. Paragraph (c) applies to health benefit plans issued to~~
490 ~~a small employer who has two or more eligible employees and to~~
491 ~~health benefit plans that are issued to a small employer who has~~
492 ~~fewer than two eligible employees and that cover an employee who~~
493 ~~has had creditable coverage continually to a date not more than~~
494 ~~63 days before the effective date of the new coverage.~~
495 2.~~3.~~ For health benefit plans that are issued to a small
496 employer who has fewer than two employees and that cover an

497 employee who has not been continually covered by creditable
498 coverage within 63 days before the effective date of the new
499 coverage, preexisting condition provisions must not exclude
500 coverage for a period beyond 24 months following the employee's
501 effective date of coverage and may relate only to:
502 a. Conditions that, during the 24-month period immediately
503 preceding the effective date of coverage, had manifested
504 themselves in such a manner as would cause an ordinarily prudent
505 person to seek medical advice, diagnosis, care, or treatment or
506 for which medical advice, diagnosis, care, or treatment was
507 recommended or received; or
508 b. A pregnancy existing on the effective date of coverage.
509 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
510 (b) For all small employer health benefit plans that are
511 subject to this section and issued by small employer carriers on
512 or after January 1, 1994, premium rates for health benefit plans
513 are subject to the following:
514 1. Small employer carriers must use a modified community
515 rating methodology in which the premium for each small employer
516 is determined solely on the basis of the eligible employee's and
517 eligible dependent's gender, age, family composition, tobacco
518 use, or geographic area as determined under paragraph (5)(e)
519 ~~(5)(f)~~ and in which the premium may be adjusted as permitted by
520 this paragraph. A small employer carrier is not required to use
521 gender as a rating factor for a nongrandfathered health plan.
522 2. Rating factors related to age, gender, family
523 composition, tobacco use, or geographic location may be
524 developed by each carrier to reflect the carrier's experience.
525 The factors used by carriers are subject to office review and

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526 approval.
527 3. Small employer carriers may not modify the rate for a
528 small employer for 12 months from the initial issue date or
529 renewal date, unless the composition of the group changes or
530 benefits are changed. However, a small employer carrier may
531 modify the rate one time within the 12 months after the initial
532 issue date for a small employer who enrolls under a previously
533 issued group policy that has a common anniversary date for all
534 employers covered under the policy if:
535 a. The carrier discloses to the employer in a clear and
536 conspicuous manner the date of the first renewal and the fact
537 that the premium may increase on or after that date.
538 b. The insurer demonstrates to the office that efficiencies
539 in administration are achieved and reflected in the rates
540 charged to small employers covered under the policy.
541 4. A carrier may issue a group health insurance policy to a
542 small employer health alliance or other group association with
543 rates that reflect a premium credit for expense savings
544 attributable to administrative activities being performed by the
545 alliance or group association if such expense savings are
546 specifically documented in the insurer's rate filing and are
547 approved by the office. Any such credit may not be based on
548 different morbidity assumptions or on any other factor related
549 to the health status or claims experience of any person covered
550 under the policy. This subparagraph does not exempt an alliance
551 or group association from licensure for activities that require
552 licensure under the insurance code. A carrier issuing a group
553 health insurance policy to a small employer health alliance or
554 other group association shall allow any properly licensed and

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555 appointed agent of that carrier to market and sell the small
556 employer health alliance or other group association policy. Such
557 agent shall be paid the usual and customary commission paid to
558 any agent selling the policy.
559 5. Any adjustments in rates for claims experience, health
560 status, or duration of coverage may not be charged to individual
561 employees or dependents. For a small employer's policy, such
562 adjustments may not result in a rate for the small employer
563 which deviates more than 15 percent from the carrier's approved
564 rate. Any such adjustment must be applied uniformly to the rates
565 charged for all employees and dependents of the small employer.
566 A small employer carrier may make an adjustment to a small
567 employer's renewal premium, up to 10 percent annually, due to
568 the claims experience, health status, or duration of coverage of
569 the employees or dependents of the small employer. If the
570 aggregate resulting from the application of such adjustment
571 exceeds the premium that would have been charged by application
572 of the approved modified community rate by 4 percent for the
573 current policy term, the carrier shall limit the application of
574 such adjustments only to minus adjustments. For any subsequent
575 policy term, if the total aggregate adjusted premium actually
576 charged does not exceed the premium that would have been charged
577 by application of the approved modified community rate by 4
578 percent, the carrier may apply both plus and minus adjustments.
579 A small employer carrier may provide a credit to a small
580 employer's premium based on administrative and acquisition
581 expense differences resulting from the size of the group. Group
582 size administrative and acquisition expense factors may be
583 developed by each carrier to reflect the carrier's experience

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584 and are subject to office review and approval.
585 6. A small employer carrier rating methodology may include
586 separate rating categories for one dependent child, for two
587 dependent children, and for three or more dependent children for
588 family coverage of employees having a spouse and dependent
589 children or employees having dependent children only. A small
590 employer carrier may have fewer, but not greater, numbers of
591 categories for dependent children than those specified in this
592 subparagraph.
593 7. Small employer carriers may not use a composite rating
594 methodology to rate a small employer with fewer than 10
595 employees. For the purposes of this subparagraph, the term
596 "composite rating methodology" means a rating methodology that
597 averages the impact of the rating factors for age and gender in
598 the premiums charged to all of the employees of a small
599 employer.
600 8. A carrier may separate the experience of small employer
601 groups with fewer than 2 eligible employees from the experience
602 of small employer groups with 2-50 eligible employees for
603 purposes of determining an alternative modified community
604 rating.
605 a. If a carrier separates the experience of small employer
606 groups, the rate to be charged to small employer groups of fewer
607 than 2 eligible employees may not exceed 150 percent of the rate
608 determined for small employer groups of 2-50 eligible employees.
609 However, the carrier may charge excess losses of the experience
610 pool consisting of small employer groups with less than 2
611 eligible employees to the experience pool consisting of small
612 employer groups with 2-50 eligible employees so that all losses

613 are allocated and the 150-percent rate limit on the experience
614 pool consisting of small employer groups with less than 2
615 eligible employees is maintained.
616 b. Notwithstanding s. 627.411(1), the rate to be charged to
617 a small employer group of fewer than 2 eligible employees,
618 insured as of July 1, 2002, may be up to 125 percent of the rate
619 determined for small employer groups of 2-50 eligible employees
620 for the first annual renewal and 150 percent for subsequent
621 annual renewals.
622 9. A carrier shall separate the experience of grandfathered
623 health plans from nongrandfathered health plans for determining
624 rates.
625 Section 18. Subsection (1) and paragraph (c) of subsection
626 (2) of section 627.6741, Florida Statutes, are amended to read:
627 627.6741 Issuance, cancellation, nonrenewal, and
628 replacement.—
629 (1)(a) An insurer issuing Medicare supplement policies in
630 this state shall offer the opportunity of enrolling in a
631 Medicare supplement policy, without conditioning the issuance or
632 effectiveness of the policy on, and without discriminating in
633 the price of the policy based on, the medical or health status
634 or receipt of health care by the individual:
635 1. To any individual who is 65 years of age or older, or
636 under 65 years of age and eligible for Medicare by reason of
637 disability or end-stage renal disease, and who resides in this
638 state, upon the request of the individual during the 6-month
639 period beginning with the first month in which the individual
640 has attained 65 years of age and is enrolled in Medicare Part B,
641 or is eligible for Medicare by reason of a disability or end-

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642 stage renal disease, and is enrolled in Medicare Part B; or
643 2. To any individual who is 65 years of age or older, or
644 under 65 years of age and eligible for Medicare by reason of a
645 disability or end-stage renal disease, who is enrolled in
646 Medicare Part B, and who resides in this state, upon the request
647 of the individual during the 2-month period following
648 termination of coverage under a group health insurance policy.
649 (b) The 6-month period to enroll in a Medicare supplement
650 policy for an individual who is under 65 years of age and is
651 eligible for Medicare by reason of disability or end-stage renal
652 disease and otherwise eligible under subparagraph (a)1. or
653 subparagraph (a)2. and first enrolled in Medicare Part B before
654 October 1, 2009, begins on October 1, 2009.
655 (c) A company that has offered Medicare supplement policies
656 to individuals under 65 years of age who are eligible for
657 Medicare by reason of disability or end-stage renal disease
658 before October 1, 2009, may, for one time only, effect a rate
659 schedule change that redefines the age bands of the premium
660 classes without activating the period of discontinuance required
661 by s. 627.410(6)(e)2.
662 (d) As a part of an insurer's rate filings, before and
663 including the insurer's first rate filing for a block of policy
664 forms in 2015, notwithstanding the provisions of s.
665 627.410(6)(e)3., an insurer shall consider the experience of the
666 policies or certificates for the premium classes including
667 individuals under 65 years of age and eligible for Medicare by
668 reason of disability or end-stage renal disease separately from
669 the balance of the block so as not to affect the other premium
670 classes. For filings in such time period only, credibility of

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671 that experience shall be as follows: if a block of policy forms
672 has 1,250 or more policies or certificates in force in the age
673 band including ages under 65 years of age, full or 100-percent
674 credibility shall be given to the experience; and if fewer than
675 250 policies or certificates are in force, no or zero-percent
676 credibility shall be given. Linear interpolation shall be used
677 for in-force amounts between the low and high values. Florida-
678 only experience shall be used if it is 100-percent credible. If
679 Florida-only experience is not 100-percent credible, a
680 combination of Florida-only and nationwide experience shall be
681 used. If Florida-only experience is zero-percent credible,
682 nationwide experience shall be used. The insurer may file its
683 initial rates and any rate adjustment based upon the experience
684 of these policies or certificates or based upon expected claim
685 experience using experience data of the same company, other
686 companies in the same or other states, or using data publicly
687 available from the Centers for Medicaid and Medicare Services if
688 the insurer's combined Florida and nationwide experience is not
689 100-percent credible, separate from the balance of all other
690 Medicare supplement policies.
691
692 A Medicare supplement policy issued to an individual under
693 subparagraph (a)1. or subparagraph (a)2. may not exclude
694 benefits based on a preexisting condition if the individual has
695 a continuous period of creditable coverage, as defined in s.
696 627.6562(3) ~~s. 627.6561(5)~~, of at least 6 months as of the date
697 of application for coverage.
698 (2) For both individual and group Medicare supplement
699 policies:

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700 (c) If a Medicare supplement policy or certificate replaces
701 another Medicare supplement policy or certificate or creditable
702 coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, the
703 replacing insurer shall waive any time periods applicable to
704 preexisting conditions, waiting periods, elimination periods,
705 and probationary periods in the new Medicare supplement policy
706 for similar benefits to the extent such time was spent under the
707 original policy~~, subject to the requirements of s. 627.6561(6)-~~
708 ~~(11)~~.
709 Section 19. Paragraphs (f) and (h) of subsection (1) of
710 section 641.185, Florida Statutes, are amended to read:
711 641.185 Health maintenance organization subscriber
712 protections.—
713 (1) With respect to the provisions of this part and part
714 III, the principles expressed in the following statements shall
715 serve as standards to be followed by the commission, the office,
716 the department, and the Agency for Health Care Administration in
717 exercising their powers and duties, in exercising administrative
718 discretion, in administrative interpretations of the law, in
719 enforcing its provisions, and in adopting rules:
720 (f) A health maintenance organization subscriber should
721 receive the flexibility to transfer to another Florida health
722 maintenance organization, regardless of health status, pursuant
723 to ss. 641.228, 641.3104, ~~641.3107,~~ 641.3111, 641.3921, and
724 641.3922.
725 (h) A health maintenance organization that issues a group
726 health contract must~~: provide coverage for preexisting~~
727 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
728 coverage pursuant to s. 641.31074,~~;~~ provide notice of

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729 cancellation pursuant to s. 641.3108,~~;~~ provide extension of
730 benefits pursuant to s. 641.3111,~~;~~ provide for conversion on
731 termination of eligibility pursuant to s. 641.3921,~~;~~ and provide
732 for conversion contracts and conditions pursuant to s. 641.3922.
733 Section 20. Subsection (2) and paragraph (a) of subsection
734 (40) of section 641.31, Florida Statutes, are amended to read:
735 641.31 Health maintenance contracts.—
736 (2) The rates charged by any health maintenance
737 organization to its subscribers shall not be excessive,
738 inadequate, or unfairly discriminatory or follow a rating
739 methodology that is inconsistent, indeterminate, or ambiguous or
740 encourages misrepresentation or misunderstanding. ~~A law~~
741 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
742 ~~annual or lifetime maximum payments shall not apply to any~~
743 ~~health maintenance organization contract that provides coverage~~
744 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
745 ~~individual or a group of 51 or more persons.~~ The commission, in
746 accordance with generally accepted actuarial practice as applied
747 to health maintenance organizations, may define by rule what
748 constitutes excessive, inadequate, or unfairly discriminatory
749 rates and may require whatever information it deems necessary to
750 determine that a rate or proposed rate meets the requirements of
751 this subsection.
752 (40)(a) Any group rate, rating schedule, or rating manual
753 for a health maintenance organization policy, which provides
754 creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~,
755 filed with the office shall provide for an appropriate rebate of
756 premiums paid in the last policy year, contract year, or
757 calendar year when the majority of members of a health plan are

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758 enrolled in and have maintained participation in any health
759 wellness, maintenance, or improvement program offered by the
760 group contract holder. The group must provide evidence of
761 demonstrative maintenance or improvement of his or her health
762 status as determined by assessments of agreed-upon health status
763 indicators between the group and the health insurer, including,
764 but not limited to, reduction in weight, body mass index, and
765 smoking cessation. Any rebate provided by the health maintenance
766 organization is presumed to be appropriate unless credible data
767 demonstrates otherwise, or unless the rebate program requires
768 the insured to incur costs to qualify for the rebate which
769 equals or exceeds the value of the rebate but the rebate may not
770 exceed 10 percent of paid premiums.
771 Section 21. Section 641.31071, Florida Statutes, is
772 repealed.
773 Section 22. Subsection (4) of section 641.3111, Florida
774 Statutes, is amended to read:
775 641.3111 Extension of benefits.—
776 ~~(4) Except as provided in subsection (1), no subscriber is~~
777 ~~entitled to an extension of benefits if the termination of the~~
778 ~~contract by the health maintenance organization is based upon~~
779 ~~any event referred to in s. 641.3922(7)(a), (b), or (c).~~
780 Section 23. Section 641.312, Florida Statutes, is amended
781 to read:
782 641.312 Scope.—The Office of Insurance Regulation may adopt
783 rules to administer the provisions of the National Association
784 of Insurance Commissioners' Uniform Health Carrier External
785 Review Model Act, issued by the National Association of
786 Insurance Commissioners and dated April 2010. This section does

787 not apply to a health maintenance contract that is subject to
788 the Subscriber Assistance Program under s. 408.7056 or to the
789 types of benefits or coverages provided under s. 627.6513(1)-
790 (14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.
791 Section 24. This act shall take effect July 1, 2016.

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