CHAPTER 2005-231

House Bill No. 811

An act relating to health insurance; amending s. 408.05, F.S.; changing the due date for a report from the Agency for Health Care Administration regarding the State Center for Health Statistics; amending s. 408.909, F.S.; providing an additional criterion for the Office of Insurance Regulation to disapprove or withdraw approval of health flex plans; amending s. 627.413, F.S.; authorizing insurers and health maintenance organizations to offer policies or contracts providing for a high-deductible plan meeting federal requirements and in conjunction with a health savings account; amending s. 627.638, F.S.; revising direct payment provisions for insurers; amending s. 627.6402, F.S.; revising the requirements for the healthy lifestyle premium rebate; amending s. 627.65626, F.S.; providing insurance rebates for healthy lifestyles; amending s. 627.6692, F.S.; extending a time period within which eligible employees may apply for continuation of coverage; amending s. 627.6699, F.S.; revising standards for determining applicability of the Employee Health Care Access Act; prescribing acts that may be performed by an employer without being considered contributing to premiums or facilitating administration of a policy; authorizing certain carriers to offer coverage to certain employees without being subject to the act under certain circumstances; requiring a carrier who offers such coverage to provide notice to the primary insured prior to cancellation for nonpayment of premium; revising an availability of coverage provision of the Employee Health Care Access Act; including high-deductible plans meeting federal health savings account plan requirements; revising membership of the board of the small employer health reinsurance program; revising certain reporting dates relating to program losses and assessments; requiring the board to advise executive and legislative entities on health insurance issues; providing requirements; amending s. 641.27, F.S.; increasing the interval at which the office examines health maintenance organizations; deleting authorization for the office to accept an audit report from a certified public accountant in lieu of conducting its own examination; increasing an expense limitation; amending s. 641.31, F.S.; providing for an insurance rebate for members in a health wellness program; providing for the rebate to cease under certain conditions; providing effective dates.

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

Section 1. Paragraph (l) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 State Center for Health Statistics.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(l) Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January ~~March~~ 1, 2006 ~~2005~~, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The agency shall determine which conditions and procedures, performance outcomes, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which performance outcomes to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall consider such measures as average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which performance outcome and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copay-

ments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information System Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified in subparagraph 1. shall be released no later than January 1, 2006, for the reporting of infection rates, and no later than October 1, 2005, for mortality rates and complication rates ~~March 1, 2005~~. The data specified in subparagraph 2. shall be released no later than October ~~March~~ 1, 2006.

Section 2. Paragraph (b) of subsection (3) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(3) PROGRAM.—The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; ~~or~~

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).

Section 3. Subsection (6) is added to section 627.413, Florida Statutes, to read:

627.413 Contents of policies, in general; identification.—

(6) Notwithstanding any other provision of the Florida Insurance Code that is in conflict with federal requirements for a health savings account qualified high-deductible health plan, an insurer, or a health maintenance organization subject to part I of chapter 641, which is authorized to issue health insurance in this state may offer for sale an individual or group policy or contract that provides for a high-deductible plan that meets the federal requirements of a health savings account plan and which is offered in conjunction with a health savings account.

Section 4. Subsection (2) of section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, medical services.—

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital, ~~or~~ physician, or dentist, the insurer shall make such payment to the designated provider of such services, unless otherwise provided in the insurance contract. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, physician, or dentist for care provided pursuant to s. 395.1041. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

Section 5. Section 627.6402, Florida Statutes, is amended to read:

627.6402 Insurance rebates for healthy lifestyles.—

(1) Any rate, rating schedule, or rating manual for an individual health insurance policy filed with the office may ~~shall~~ provide for an appropriate rebate of premiums paid in the last ~~calendar~~ year when the individual covered by such plan is enrolled in and maintains participation in any health wellness, maintenance, or improvement program approved by the health plan. The rebate may be based on premiums paid in the last calendar year or the last policy year. The individual must provide evidence of demonstrative maintenance or improvement of the individual's health status as determined by assessments of agreed-upon health status indicators between the individual and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless such rebate program requires the insured to incur costs to qualify for the rebate which equal or exceed the value of the rebate, but in no event shall the rebate ~~not~~ exceed 10 percent of paid premiums.

(2) The premium rebate authorized by this section shall be effective for an insured on an annual basis, unless the individual fails to maintain or improve his or her health status while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program.

Section 6. Section 627.65626, Florida Statutes, is amended to read:

627.65626 Insurance rebates for healthy lifestyles.—

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

(2) The premium rebate authorized by this section shall be effective for an insured on an annual basis unless the number of participating members on the policy renewal anniversary ~~employees~~ becomes less than the majority of the members ~~employees~~ eligible for participation in the wellness program.

Section 7. Paragraphs (d) and (j) of subsection (5) of section 627.6692, Florida Statutes, are amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.—

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.—

(d)1. A qualified beneficiary must give written notice to the insurance carrier within 63 ~~30~~ days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries. The written notice must inform the insurance carrier of the occurrence and type of the qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that insurance carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. The

written notice must, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by the insurance carrier under the terms of the group health plan or the commission by rule, to the extent that such information is known by the qualified beneficiary.

2. Within 14 days after the receipt of written notice under subparagraph 1., the insurance carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the office, which form must provide for the qualified beneficiary's election or nonelection of continuation of coverage under the group health plan and the applicable premium amount due after the election to continue coverage. This subparagraph does not require separate mailing of notices to qualified beneficiaries residing in the same household, but requires a separate mailing for each separate household.

(j) Notwithstanding paragraph (b), if a qualified beneficiary in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the group plan is terminated by the beneficiary or the carrier due to the qualified beneficiary becoming eligible for TRICARE (the health care program provided by the United States Defense Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 ~~30~~ days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

Section 8. Paragraph (a) of subsection (4), paragraph (c) of subsection (5), and paragraphs (b) and (j) of subsection (11) of section 627.6699, Florida Statutes, are amended, and paragraph (o) is added to subsection (11) of that section, to read:

627.6699 Employee Health Care Access Act.—

(4) APPLICABILITY AND SCOPE.—

(a)1. This section applies to a health benefit plan that provides coverage to employees of a small employer in this state, unless the coverage ~~policy~~ is marketed directly to the individual employee, and the employer does not contribute directly or indirectly to ~~participate in~~ the ~~collection or distribution of~~ premiums or facilitate the administration of the coverage ~~policy~~ in any manner. For the purposes of this subparagraph, an employer is not deemed to be contributing to the premiums or facilitating the administration of coverage if the employer does not contribute to the premium and merely collects the premiums for coverage from an employee's wages or salary through payroll deduction and submits payment for the premiums of one or more employees in a lump sum to a carrier.

2. A carrier authorized to issue group or individual health benefit plans under this chapter or chapter 641 may offer coverage as described in this paragraph to individual employees without being subject to this section if the employer has not had a group health benefit plan in place in the prior 6 months. A carrier authorized to issue group or individual health benefit plans under this chapter or chapter 641 may offer coverage as described in this subparagraph to employees that are not eligible employees as defined in this section, whether or not the small employer has a group health benefit plan in place. A carrier that offers coverage as described in this subparagraph must provide a cancellation notice to the primary insured at least 10 days prior to canceling the coverage for nonpayment of premium.

(5) AVAILABILITY OF COVERAGE.—

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. In the absence of enrollment availability in the Florida Health Insurance Plan, offer and issue basic and standard small employer health benefit plans and a high-deductible plan that meets the requirements of a health savings account plan or health reimbursement account as defined by federal law, on a guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.

3. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

(b)1. The program shall operate subject to the supervision and control of the board.

2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:

a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration. ~~The director of the office shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the commission. Three members shall be selected from a list of health insurance carriers that issue individual health insurance policies. At least two of the three members selected must be reinsuring carriers. Two members shall be selected from a list of insurance agents who are actively engaged in the sale of health insurance.~~

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

3. The director of the office may remove a member for cause.

4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

~~5. The director of the office may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.~~

(j)1. Before July ~~March~~ 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for

the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before <u>July</u> ~~March~~ 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the

amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 ~~90~~ days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 ~~90~~ days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(o) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.

2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.

3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.

4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.

5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

Section 9. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.—

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 ~~3~~ years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part.~~ However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations exceed a maximum of $50,000 ~~$20,000~~ for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, reorganization, conservation, or dissolution of life insurance companies.

Section 10. Subsection (40) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6561(5), filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health ~~individual covered by such~~ plan are ~~is~~ enrolled in and maintained ~~maintains~~ participation in any health wellness, maintenance, or improvement program offered by the group contract holder ~~approved by the health plan~~. The group ~~individual~~ must provide evidence of demonstrative maintenance or improvement of his or her health

status as determined by assessments of agreed-upon health status indicators between the group ~~individual~~ and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization ~~insurer~~ is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may ~~shall~~ not exceed 10 percent of paid premiums.

(b) The premium rebate authorized by this section shall be effective for a subscriber ~~an insured~~ on an annual basis, unless the number of participating members on the contract renewal anniversary becomes fewer than the majority of the members eligible for participation in the wellness program ~~individual fails to maintain or improve his or her health status while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program~~.

(c) A health maintenance organization that issues individual contracts may offer a premium rebate, as provided under this section, for a healthy lifestyle program.

Section 11. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon becoming a law, this act shall take effect July 1, 2005, and shall apply to all policies or contracts issued or renewed on or after July 1, 2005.

Approved by the Governor June 14, 2005.

Filed in Office Secretary of State June 14, 2005.