FLORIDA OFFICE OF INSURANCE REGULATION

Division of Life and Health Product Review

The Florida Office of Insurance Regulation (Office) developed the following worksheet to assist HMOs in making form filings that are compliant with ACA (Affordable Care Act) requirements, effective January 1, 2014. The Office encourages the HMO to download, complete, scan and upload this form as a part of the form filing intended to be compliant with the 2014 ACA requirements submitted to the Office via I-File. This will expedite the review process and increase speed to market. This worksheet will be updated on a continuing basis as additional federal guidance is issued. You are encouraged to use the most recently updated version. The worksheet may not contain all of the requirements of the ACA. The Office offers this worksheet as guidance only, and should not be considered a directive by the Office.

HMO Individual Application Review Form

Florida Provisions (Blue); ACA Provisions (Red)

(GP) Grandfather Plan (NGP) Non-Grandfather Plan (EHB) Essential Health Benefits

Statute/Rule	Description	Yes	No	N/A	Page #
69O-191.051	Review filings for correct product codes, properly completed UDL, inclusion of all required documents for a complete review and other requirements. Incorrect product codes and incomplete filings will be returned as incomplete with a letter of explanation.				
69O-191.051	Required information to be submitted within the filing.				
69O-191.051	Provide the Office with the form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 01-23456), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted.				
69O-191.051(2)	Application shall contain a unique form number in the lower left-hand corner.				
45 CFR 155.205	Issuers must provide applicant information in plain language and in a manner that is accessible and timely. Required notices must meet certain specified standards.				
641.3007(4)(e)	HIV and AIDS: Application can ask only if tested positive or been diagnosed.				
~~641.31095~~ PPACA 1001 [PHSA 2713 (a)]; PPACA 1302(b)(1)(I)	~~Coverage for mammograms: The option to have the deductible/co-payment applicable to mammograms waived shall be contained in the individual application.~~ Coverage not optional; included in the Preventative and Wellness Services Essential Health Benefit.				

627.6419	An HMO may not exclude or deny coverage solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to, or solely due to a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than 2 years before request for coverage.				
PHSA 2705; 45 CFR 146.121; 45 CFR 147.110	Eligibility for coverage based on specified health factors. A plan may not establish rules for eligibility based on any of the following health-related factors: health status, medical condition, claims experience, receipt of health care, medical history, general information, evidence of insurability, disability and any other health status-related factor deemed appropriate by the HHS Secretary.				
641.31(3)(c)5.	Questions in the application concerning medical conditions should be phrased so as to solicit responses that may be supported by the applicant's medical records. This is accomplished by asking for "diagnosis or treatment" by a "licensed medical professional."				
641.386	Agent licensing and appointment required: Application shall be signed by a Florida licensed agent or regular salaried officer or employee of the HMO.				
PHSA 2753; 45 CFR 148.180	Coverage is not based on genetic information (GINA). An issuer is not allowed to: adjust premiums based on genetic information, request or require genetic testing or collect genetic information from an individual prior to or in connection with enrollment in a plan, or at any time for underwriting purposes.				
817.234(1)(b) and Bulletin 96-001	Fraud Statement: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."				
69O-128.018	Authorization to release medical information				
69O-128.018(1)(b)	Authorization to release information: general description of information to be disclosed.				
69O-128.018(1)(c)	Authorization to release information: general description of parties involved with the information.				
69O-128.018(1)(d)	Authorization to release information: insured's signature.				
69O-128.018(2)	Authorization to release information: valid for only 24 months.				
69O-128.018(3)	Authorization to release information: insured's signature may be revoked at any time.				