

1 A bill to be entitled
2 An act relating to health care regulations; creating
3 s. 381.02033, F.S.; establishing the Prescription Drug
4 Affordability Commission within the Agency for Health
5 Care Administration; providing a purpose; providing
6 definitions; providing requirements for membership,
7 terms of service, and meetings; requiring
8 manufacturers to notify the commission of proposed
9 price increases and introductory prices of
10 prescription drugs under certain circumstances;
11 providing notice requirements; requiring the
12 commission to inform the public about manufacturer
13 notices; providing requirements for reviews of
14 prescription drug costs and determination of excess
15 prescription drug costs; providing for determination
16 of prescription drug rates under certain
17 circumstances; providing penalties for noncompliance
18 with specified requirements; providing exceptions;
19 requiring the Office of the Attorney General to
20 provide guidance to stakeholders concerning certain
21 activities and transactions; authorizing certain
22 persons to appeal the decision of the commission;
23 authorizing public access to certain information;
24 establishing an advisory council; providing
25 requirements for membership and terms of service;

26 requiring the agency to provide the commission with
27 staff; requiring commission and advisory council
28 members and certain agency staff to recuse themselves
29 if there are conflicts of interest; requiring
30 disclosures of conflicts of interest; prohibiting
31 acceptance of gifts, bequests, and donations;
32 providing for per diem and travel expenses; requiring
33 the commission to annually report specified
34 information relating to prescription drug prices to
35 the Governor and the Legislature; requiring the report
36 to be posted on specified websites; providing
37 rulemaking authority; amending s. 627.6487, F.S.;
38 revising provisions relating to individual health
39 insurance coverage for preexisting conditions;
40 revising the definition of the term "preexisting
41 condition"; deleting provisions authorizing insurers
42 and health maintenance organizations to elect to limit
43 specified coverage under certain circumstances;
44 revising the conditions under which such insurers and
45 health maintenance organizations may limit enrollment
46 or deny coverage; revising construction; deleting
47 obsolete language; creating s. 627.64875, F.S.;
48 providing legislative intent; providing definitions;
49 prohibiting specified health insurers from engaging in
50 certain practices; requiring premium rates for

51 individual health insurance policies to be based on
52 certain factors; prohibiting rate modifications within
53 a specified timeframe; providing exceptions; providing
54 applicability; providing rulemaking authority to the
55 Financial Services Commission; creating s. 627.65613,
56 F.S.; providing definitions; prohibiting specified
57 insurers from declining to offer coverage under group,
58 blanket, or franchise health insurance policies to
59 certain groups, employers, and individuals;
60 prohibiting such insurers from imposing preexisting
61 condition exclusions; providing applicability;
62 providing rulemaking authority; creating s. 627.65614,
63 F.S.; providing definitions; prohibiting specified
64 insurers from establishing, in their franchise health
65 insurance policies, differentials in premium rates
66 based on preexisting conditions; requiring premium
67 rates for franchise health insurance policies to be
68 based on certain factors; prohibiting rate
69 modifications within a specified timeframe; providing
70 exceptions; providing applicability; providing
71 rulemaking authority; amending s. 627.6699, F.S.;
72 revising legislative purpose and intent; revising the
73 definition of the term "modified community rating";
74 defining the term "preexisting condition"; deleting
75 provisions relating to preexisting condition

76 | exclusions and limits; revising the geographic rating
77 | factors used by small employer carriers; prohibiting
78 | small employer carriers from varying premium rates
79 | based on preexisting conditions; revising the rating
80 | factors that small employer carriers must use to
81 | determine and vary premiums; providing requirements
82 | for the premium rates; revising the circumstances
83 | under which small employer carriers may modify premium
84 | rates within a specified period; prohibiting certain
85 | premium credits from being based on preexisting
86 | conditions; revising prohibited activities by small
87 | employer carriers; deleting obsolete language;
88 | deleting specified information that small employer
89 | carriers must disclose under certain circumstances;
90 | creating s. 641.1855, F.S.; providing definitions;
91 | prohibiting certain health maintenance organizations
92 | from establishing, in individual and small employer
93 | health maintenance contracts, differentials in premium
94 | rates based on preexisting conditions; requiring
95 | premium rates for such contracts to be based on
96 | certain factors; prohibiting rate modifications within
97 | a specified timeframe; providing exceptions; providing
98 | applicability; creating s. 641.31077, F.S.; providing
99 | legislative intent; providing definitions; prohibiting
100 | certain health maintenance organizations from

101 declining to offer coverage to specified groups,
102 employers, and individuals and from imposing
103 preexisting condition exclusions under a contract;
104 providing applicability; amending ss. 408.9091,
105 409.814, 627.429, 627.607, 627.6415, 627.642,
106 627.6425, 627.6426, 627.6512, 627.6525, 627.65625,
107 627.6571, 627.6578, 627.6675, 627.6692, 627.6741,
108 631.818, 641.185, 641.3007, 641.31, 641.3102,
109 641.31073, 641.31074, 641.3903, and 641.3922, F.S.;
110 conforming provisions to changes made by the act;
111 amending ss. 409.816, 627.6475, and 627.66997, F.S.;
112 conforming cross-references; repealing ss. 627.6045,
113 627.6046, 627.6561, 627.65612, and 641.31071, F.S.,
114 relating to preexisting conditions and limits on
115 preexisting conditions; providing an effective date.

116

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

118

119 Section 1. Section 381.02033, Florida Statutes, is created
120 to read:

121 381.02033 Prescription Drug Affordability Commission.—

122 There is established the Prescription Drug Affordability
123 Commission, a commission as defined in s. 20.03. The commission
124 shall review manufacturers' prices, price increases, and
125 introductory prices of prescription drugs and shall determine

126 the reasonableness of these prices, price increases, and
127 introductory prices, to ensure prescription drug affordability
128 for the state health care system. The commission shall comply
129 with the requirements of s. 20.052, except as otherwise provided
130 in this section, and shall be administratively housed within the
131 Agency for Health Care Administration.

132 (1) DEFINITIONS.—As used in this section, the term:

133 (a) "Agency" means the Agency for Health Care
134 Administration.

135 (b) "Commission" means the Prescription Drug Affordability
136 Commission.

137 (c) "Conflict of interest" means:

138 1. An association, including a financial or personal
139 association, that has the potential to bias or has the
140 appearance of biasing an individual's decisions in matters
141 related to the commission or the conduct of the commission's
142 activities; or

143 2. Any instance in which an individual has received or
144 could receive either of the following:

145 a. A direct financial benefit of any amount deriving from
146 the results or findings of a study or determination by or for
147 the commission; or

148 b. A financial benefit that, in the aggregate, exceeds
149 \$5,000 per year and that derives from a company or another
150 individual who owns or manufactures prescription drugs,

151 services, or items to be studied by the commission. As used in
152 this sub-subparagraph, the term "financial benefit" includes,
153 but is not limited to, an honorarium, a fee, a stock, or an
154 increase in the value of an individual's existing stockholdings.

155 (d) "Excess cost" means the cost of appropriate use of a
156 prescription drug that:

157 1. Exceeds the therapeutic benefit relative to other
158 therapeutic options or alternative treatments;

159 2. Exceeds the cost of the same prescription drug in
160 another country or another state by 25 percent; or

161 3. Is not sustainable to public and private health care
162 systems over a 10-year timeframe.

163 (e) "Office" means the Office of the Attorney General,
164 unless the context clearly indicates otherwise.

165 (f) "Trade secret" has the same meaning as defined in s.
166 688.002.

167 (2) MEMBERSHIP OF THE COMMISSION; APPOINTMENT; TERMS OF
168 SERVICE.—

169 (a) The commission shall consist of five members with
170 expertise in health economics or clinical medicine, who shall be
171 appointed as follows:

172 1. Two members appointed by the President of the Senate.
173 The President of the Senate shall also appoint one alternate
174 commission member, who shall participate in deliberations of the
175 commission if a member appointed by the President of the Senate

176 recuses himself or herself under subsection (12).

177 2. Two members appointed by the Speaker of the House of
178 Representatives. The Speaker of the House of Representatives
179 shall also appoint one alternate commission member, who shall
180 participate in deliberations of the commission if a member
181 appointed by the Speaker of the House of Representatives recuses
182 himself or herself under subsection (12).

183 3. One member appointed by the Governor. The Governor
184 shall also appoint one alternate commission member, who shall
185 participate in deliberations of the commission if the member
186 appointed by the Governor recuses himself or herself under
187 subsection (12).

188
189 Each member and alternate member of the commission is subject to
190 confirmation by the Senate and to the dual-office-holding
191 prohibition of s. 5(a), Art. II of the State Constitution.

192 (b) Members shall serve 4-year terms, except that the
193 initial terms shall be staggered as follows:

194 1. The initial member appointed by the Governor shall
195 serve 4 years.

196 2. Of the initial two members appointed by the President
197 of the Senate, one shall serve 3 years, and one shall serve 2
198 years.

199 3. Of the initial two members appointed by the Speaker of
200 the House of Representatives, one shall serve 3 years, and one

201 shall serve 2 years.

202 (c) The Governor shall designate the chair, and the chair
203 shall designate a co-chair from among the other members of the
204 commission.

205 (d) A vacancy shall be filled for the remainder of the
206 unexpired term in the same manner as the original appointment.

207 (e) When appointing a member or alternate member to the
208 commission or a member to the advisory council, established in
209 subsection (10), the appointing authority must consider any
210 conflict of interest disclosed by the prospective member or
211 alternate member.

212 (3) MEETINGS OF THE COMMISSION.—The commission shall meet
213 in a location readily accessible to the public at least every 6
214 weeks to review prescription drug price notices submitted under
215 subsection (4). A meeting may be cancelled or postponed at the
216 discretion of the chair if there is no pending decision.

217 (a) The commission must post on its website and the
218 agency's website:

219 1. A public meeting announcement at least 2 weeks before a
220 meeting.

221 2. Meeting materials at least 1 week before a meeting.

222 (b) The commission shall provide an opportunity for the
223 public to:

224 1. Comment at a public meeting.

225 2. Submit written comments on a pending decision.

226 (c) The commission may allow expert testimony at a public
227 meeting. Any decision that the commission makes must be done in
228 a public meeting, including, but not limited to, the following
229 decisions:

230 1. Reviewing a prescription drug cost analysis.

231 2. Voting on whether to impose a cost or payment limit on
232 payors for a prescription drug.

233 (d) A majority of commission members present constitutes a
234 quorum.

235 (4) REQUIRED MANUFACTURER NOTICES.—

236 (a) A prescription drug manufacturer shall notify the
237 commission if the manufacturer intends to:

238 1.a. Increase the wholesale acquisition cost of a patent-
239 protected, brand name prescription drug by more than 10 percent,
240 or by more than \$3,000 per course of treatment, during any 12-
241 month period; or

242 b. Introduce to the market a brand name prescription drug
243 that has a wholesale acquisition cost of \$30,000 per year or per
244 course of treatment;

245 2. Introduce to the market a biosimilar drug with a
246 wholesale acquisition cost that is not at least 15 percent lower
247 than the cost of the referenced brand name biologic drug at the
248 time the biosimilar drug is introduced to the market; or

249 3.a. Increase the wholesale acquisition cost of a generic
250 or off-patent sole source brand name prescription drug by more

251 than 25 percent, or by more than \$300 per course of treatment,
252 during any 12-month period; or

253 b. Introduce to the market a generic prescription drug
254 that has a wholesale acquisition cost of \$1,200 or more per
255 year.

256
257 The prescription drug manufacturer must provide the notice in
258 writing at least 30 days before the planned effective date of
259 the increase or introduction and must include a price
260 justification pursuant to paragraph (c).

261 (b) The commission may, after consultation with the
262 advisory council, require any prescription drug manufacturer to
263 provide notice to the commission and to include a price
264 justification pursuant to paragraph (c) for any prescription
265 drug that creates a challenge to prescription drug affordability
266 for the state health care system.

267 (c) The prescription drug manufacturer must justify a
268 proposed price increase or introductory price of a prescription
269 drug as specified in paragraph (a) or an actual or proposed
270 price, price increase, or introductory price of a prescription
271 drug described in paragraph (b) by providing all documents and
272 research related to the manufacturer's selection of the price,
273 price increase, or introductory price, including life cycle
274 management; net average price in the state, which is calculated
275 by the net average of all price concessions, excluding in-kind

276 concessions; market competition and context; projected revenue;
277 and, if available, estimated value and cost-effectiveness of the
278 prescription drug.

279 (5) REVIEW OF PRESCRIPTION DRUG COSTS.—

280 (a) The commission shall inform the public about all the
281 notices that prescription drug manufacturers are required to
282 provide under subsection (4). The commission must post such
283 notices on its website and the agency's website at least 1 week
284 before a public meeting on the noticed prescription drugs is
285 held.

286 (b) The commission shall undertake a cost review of all
287 prescription drugs that are the subject of a notice under
288 subsection (4) and shall review all the public's comments,
289 including written comments, provided under subsection (3) in a
290 public meeting.

291 (6) EXCESS COSTS TO PAYORS AND CONSUMERS.—

292 (a) In undertaking a cost review of a prescription drug,
293 the commission must determine if appropriate use of the
294 prescription drug which is consistent with the United States
295 Food and Drug Administration label or with standard medical
296 practice has led or will lead to excess costs for the state
297 health care system.

298 (b) The commission may consider the following factors in
299 determining costs and excess costs:

300 1. The price at which the prescription drug has been or

301 will be sold in the state.

302 2. The average monetary price concession, discount, or
 303 rebate the prescription drug manufacturer provides to payors in
 304 the state or is expected to provide to payors in the state for
 305 the prescription drug as reported by manufacturers.

306 3. The price at which therapeutic alternatives have been
 307 or will be sold in the state.

308 4. The average monetary price concession, discount, or
 309 rebate the prescription drug manufacturer provides to payors in
 310 the state or is expected to provide to payors in the state for
 311 therapeutic alternatives.

312 5. The cost of the prescription drug to payors based on
 313 patient access consistent with the United States Food and Drug
 314 Administration labeled indications or with standard medical
 315 practice.

316 6. The effect on patient access resulting from the cost of
 317 the prescription drug relative to the health benefit.

318 7. The current or expected value of manufacturer-
 319 supported, drug-specific patient access programs.

320 8. The relative financial effects on health, medical, and
 321 other social services costs as may be quantified and compared to
 322 baseline effects of existing therapeutic alternatives.

323 9. The difference between the price or proposed price of
 324 the prescription drug and the price of the same prescription
 325 drug in another country or state.

326 10. Other such factors determined relevant by the
327 commission.

328 (c) After considering the factors in paragraph (b), if the
329 commission cannot determine whether a prescription drug will
330 produce or has produced excess costs, the commission may
331 consider the following:

332 1. Manufacturer research and development costs, as shown
333 on the manufacturer's federal tax filing for the most recent tax
334 year, multiplied by the ratio of total manufacturer sales in the
335 state to total manufacturer national sales for the prescription
336 drug under review.

337 2. That portion of direct-to-consumer marketing costs
338 eligible for favorable federal tax treatment in the most recent
339 tax year that are specific to the prescription drug under review
340 and that are multiplied by the ratio of total manufacturer sales
341 in the state to total manufacturer national sales for the
342 prescription drug under review.

343 3. Gross and net manufacturer revenues for the most recent
344 tax year for the prescription drug under review.

345 4. Any additional factors proposed by the manufacturer
346 that the commission determines to be relevant to the
347 circumstances for the prescription drug under review.

348 (7) COMMISSION DETERMINATIONS; COMPLIANCE; REMEDIES.—

349 (a) If the commission finds that the cost of the
350 prescription drug under review creates excess costs for payors

351 and consumers, the commission shall establish the rate that must
352 be billed to, and paid by, payors, pharmacies, health care
353 providers, wholesalers, distributors, and uninsured and insured
354 consumers.

355 (b) An affirmative vote of a majority of the commission
356 members present at a meeting is required for any action or
357 recommendation by the commission, including, but not limited to,
358 an imposition of a cost or payment limit on payors for a
359 prescription drug or an establishment of a prescription drug
360 rate.

361 (c) The failure to bill, or pay for, a prescription drug
362 at the rate established by the commission under paragraph (a)
363 constitutes a violation of this section and must be referred to
364 the office for enforcement. Upon a finding of noncompliance with
365 the commission requirements for a prescription drug rate, the
366 office may pursue any remedy available under civil and criminal
367 law. However, the office may not consider that a person is in
368 noncompliance with this section if:

369 1. A payor obtains a price concession from a manufacturer
370 that results in a payor's net cost being lower than the rate
371 established by the commission; or

372 2. The person is a consumer, whether insured or uninsured.

373
374 The office shall provide guidance to stakeholders concerning
375 activities that may be considered noncompliant and payment

376 transactions in which prescription drug costs exceed the limit
377 established by the commission.

378 (d) The failure of a prescription drug manufacturer to
379 submit a notice as required under subsection (4) constitutes a
380 violation of this section and must be referred to the office for
381 enforcement. Upon a finding of a manufacturer's noncompliance
382 with the commission requirements for notification, the office
383 may pursue any remedy available under civil law.

384 (8) APPEALS.—A person affected by a decision of the
385 commission may appeal the decision within 30 days. The full
386 commission shall consider the appeal and render a decision
387 within 60 days after receipt of the appeal. The decision of the
388 commission after appeal is subject to judicial review.

389 (9) PUBLIC ACCESS TO INFORMATION.—Information relating to
390 a prescription drug price notice submitted by a prescription
391 drug manufacturer to the commission or relating to a
392 prescription drug cost review is available to the public.

393 (10) ADVISORY COUNCIL.—There is established an advisory
394 council, as defined in s. 20.03, to advise the commission on
395 prescription drug cost issues and to represent stakeholder
396 views. The advisory council shall comply with the requirements
397 of s. 20.052, except as otherwise provided in this section, and
398 shall be administratively housed within the agency.

399 (a) The advisory council shall consist of 11 members, who
400 must be selected based on their knowledge of one or more of the

401 following:

- 402 1. The pharmaceutical business model.
- 403 2. Practice of medicine or clinical knowledge and
- 404 training.
- 405 3. Patients' perspectives.
- 406 4. Health care cost trends and drivers.
- 407 5. Clinical and health services research.
- 408 6. The state health care marketplace in general.

409 (b) Members of the advisory council shall be appointed as
 410 follows:

411 1. Six members appointed by the Secretary of Health Care
 412 Administration, each member representing a different group as

413 follows:

- 414 a. Physicians
- 415 b. Nurses.
- 416 c. Hospitals.
- 417 d. Health insurers.
- 418 e. A statewide health care advocacy coalition.
- 419 f. A statewide senior advocacy coalition.

420 2. Five members appointed by the Governor, each member
 421 representing a different group as follows:

- 422 a. Pharmaceutical manufacturers.
- 423 b. Pharmaceutical employers.
- 424 c. Pharmacists.
- 425 d. Prescription drug research specialists.

426 e. The public.

427 (c) Members of the advisory council shall serve 4-year
428 terms, except that the initial terms shall be staggered as
429 follows:

430 1. Of the initial six members appointed by the Secretary
431 of Health Care Administration, two shall serve for 4 years, two
432 shall serve for 3 years, and two shall serve for 2 years.

433 2. Of the initial five members appointed by the Governor,
434 two shall serve for 4 years, two shall serve for 3 years, and
435 one shall serve for 1 year.

436 (d) The Governor shall designate the chair, and the chair
437 shall designate a co-chair from among the other members of the
438 advisory council. A vacancy shall be filled for the remainder of
439 the unexpired term in the same manner as the original
440 appointment.

441 (11) COMMISSION STAFF.—The agency shall provide staff and
442 other administrative assistance necessary to assist the
443 commission in carrying out its responsibilities.

444 (12) CONFLICTS OF INTEREST.—The following provisions
445 govern any conflict of interest for a commission or advisory
446 council member or for an agency staff member who assists the
447 commission:

448 (a)1. If a commission or advisory council member, or an
449 immediate family member thereof, has a conflict of interest as
450 defined in subparagraph (1)(c)1. or subparagraph (1)(c)2. that

451 is related to a prescription drug under review, the commission
452 or advisory council member, as applicable, shall recuse himself
453 or herself from any board activity involving such prescription
454 drug, including the review of the prescription drug.

455 2. If an agency staff member who assists the commission
456 has a conflict of interest as defined in subparagraph (1)(c)2.
457 that is related to a prescription drug under review, the staff
458 member shall recuse himself or herself from the review of the
459 prescription drug.

460 (b)1. A conflict of interest must be disclosed by:

461 a. The Governor, the President of the Senate, or the
462 Speaker of the House of Representatives, as applicable, when
463 appointing members to the commission.

464 b. The Governor or the Secretary of Health Care
465 Administration, as applicable, when appointing members to the
466 advisory council.

467 c. The commission when:

468 (I) Being assisted by senior agency staff; or

469 (II) Describing any recusal as part of a final decision
470 resulting from a review of a prescription drug.

471 2. The commission must post a conflict of interest on its
472 website and the agency's website within 5 days after a conflict
473 of interest is identified. If a public meeting of the commission
474 occurs within that 5-day period, the commission must post the
475 conflict of interest on both websites within 12 hours after the

476 conflict of interest is identified or in advance of the public
477 meeting, whichever is earlier.

478 3. The information disclosed on the conflict of interest
479 must include the type, nature, and magnitude of the conflict of
480 interest of the individual involved, except to the extent that
481 the individual recuses himself or herself from participation in
482 any activity in which the potential conflict of interest exists.

483 (c) A commission or advisory council member or an agency
484 staff member assisting the commission may not accept a gift, a
485 bequest, or a donation of services or property that suggests a
486 conflict of interest or has the appearance of creating bias in
487 the work of the commission or advisory council.

488 (13) COMPENSATION.—A commission or advisory council member
489 shall serve without compensation but shall be reimbursed for per
490 diem and travel expenses in accordance with s. 112.061.

491 (14) ANNUAL REPORTS.—Beginning January 1, 2021, and
492 annually thereafter, the commission shall report to the
493 Governor, the President of the Senate, and the Speaker of the
494 House of Representatives on general prescription drug price
495 trends, the number of prescription drug manufacturers required
496 to provide notice under this section, and the number of
497 prescription drugs that were subject to commission review and
498 analysis, including the results of such analysis, as well as the
499 number and disposition of appeals and judicial reviews. The
500 commission shall post the report on its website and the agency's

501 website in a manner that is readily accessible to the public.

502 (15) RULEMAKING.—The agency may adopt rules to implement
 503 and administer this section.

504 Section 2. Section 627.6487, Florida Statutes, is amended
 505 to read:

506 627.6487 Guaranteed availability of individual health
 507 insurance coverage to eligible individuals.—

508 (2)~~(1)~~ Subject to the requirements of this section, each
 509 health insurance issuer that offers individual health insurance
 510 coverage in this state may not, with respect to an eligible
 511 individual who desires to enroll in individual health insurance
 512 coverage:

513 (a) Decline to offer such coverage to, or deny enrollment
 514 of, such individual; ~~or~~

515 (b) Impose any preexisting condition exclusion with
 516 respect to such coverage; or

517 (c) Establish differentials in premium rates for such
 518 coverage based on a preexisting condition. ~~For purposes of this~~
 519 ~~section, the term "preexisting condition" means, with respect to~~
 520 ~~coverage, a limitation of benefits relating to a condition based~~
 521 ~~on the fact that the condition was present before the date of~~
 522 ~~enrollment for such coverage, whether or not any medical advice,~~
 523 ~~diagnosis, care, or treatment was recommended or received before~~
 524 ~~such date.~~

525 (1)~~(2)~~ As used in ~~For the purposes of this section, the~~

526 term:

527 (b)~~(a)~~ "Health insurance issuer" and "issuer" mean an
528 authorized insurer or a health maintenance organization.

529 (c)~~(b)~~ "Individual health insurance" means health
530 insurance, as defined in s. 624.603, which is offered to an
531 individual, including certificates of coverage offered to
532 individuals in this state as part of a group policy issued to an
533 association outside this state, but the term does not include
534 short-term limited duration insurance or excepted benefits
535 specified in s. 627.6513(1)-(14).

536 ~~(a)(3) For the purposes of this section, the term~~
537 "Eligible individual" means an individual:

538 1.a.~~(a)1.~~ For whom, as of the date on which the individual
539 seeks coverage under this section, the aggregate of the periods
540 of creditable coverage, as defined in s. 627.6562(3), is 18 or
541 more months; and

542 b.(I)2.a. Whose most recent prior creditable coverage was
543 under a group health plan, governmental plan, or church plan, or
544 health insurance coverage offered in connection with any such
545 plan; or

546 (II)b. Whose most recent prior creditable coverage was
547 under an individual plan issued in this state by a health
548 insurer or health maintenance organization, which coverage is
549 terminated due to the insurer or health maintenance organization
550 becoming insolvent or discontinuing the offering of all

551 individual coverage in the State of Florida, or due to the
552 insured no longer living in the service area in the State of
553 Florida of the insurer or health maintenance organization that
554 provides coverage through a network plan in the State of
555 Florida;

556 2.~~(b)~~ Who is not eligible for coverage under:

557 a.1. A group health plan, as defined in s. 2791 of the
558 Public Health Service Act;

559 b.2. A conversion policy or contract issued by an
560 authorized insurer or health maintenance organization under s.
561 627.6675 or s. 641.3921, respectively, offered to an individual
562 who is no longer eligible for coverage under either an insured
563 or self-insured employer plan;

564 c.3. Part A or part B of Title XVIII of the Social
565 Security Act; or

566 d.4. A state plan under Title XIX of such act, or any
567 successor program, and does not have other health insurance
568 coverage;

569 3.~~(e)~~ With respect to whom the most recent coverage within
570 the coverage period described in subparagraph 1. ~~paragraph (a)~~
571 was not terminated based on a factor described in s.

572 627.6571(2) (a) or (b), relating to nonpayment of premiums or
573 fraud, unless such nonpayment of premiums or fraud was due to
574 acts of an employer or person other than the individual;

575 4.~~(d)~~ Who, having been offered the option of continuation

576 coverage under a COBRA continuation provision or under s.
577 627.6692, elected such coverage; and

578 5.(e) Who, if the individual elected such continuation
579 provision, has exhausted such continuation coverage under such
580 provision or program.

581 (d) "Preexisting condition" means a condition that was
582 present before the effective date of coverage under a health
583 insurance policy or the date of the coverage denial, regardless
584 of whether any medical advice, diagnosis, care, or treatment was
585 recommended or received for such condition before that date.

586 ~~(4) (a) The health insurance issuer may elect to limit the~~
587 ~~coverage offered under subsection (1) if the issuer offers at~~
588 ~~least two different policy forms of health insurance coverage,~~
589 ~~both of which:~~

590 ~~1. Are designed for, made generally available to, actively~~
591 ~~marketed to, and enroll both eligible and other individuals by~~
592 ~~the issuer; and~~

593 ~~2. Meet the requirement of paragraph (b).~~

594
595 ~~For purposes of this subsection, policy forms that have~~
596 ~~different cost-sharing arrangements or different riders are~~
597 ~~considered to be different policy forms.~~

598 ~~(b) The requirement of this subsection is met for health~~
599 ~~insurance coverage policy forms offered by an issuer in the~~
600 ~~individual market if the issuer offers the policy forms for~~

601 ~~individual health insurance coverage with the largest, and next~~
602 ~~to largest, premium volume of all such policy forms offered by~~
603 ~~the issuer in this state or applicable marketing or service~~
604 ~~area, as prescribed in rules adopted by the commission, in the~~
605 ~~individual market in the period involved. To the greatest extent~~
606 ~~possible, such rules must be consistent with regulations adopted~~
607 ~~by the United States Department of Health and Human Services.~~

608 (3) (a) (5) (a) In the case of a health insurance issuer that
609 offers individual health insurance coverage through a network
610 plan, the issuer may:

611 1. Limit the individuals who may be enrolled under such
612 coverage to those who live, reside, or work within the service
613 area for such network plan; and

614 2. Within the service area of such plan, deny such
615 coverage to such individuals if the issuer has demonstrated to
616 the office that:

617 a. It will not have the capacity to deliver services
618 adequately to additional individual enrollees because of its
619 obligations to existing group contract holders and enrollees and
620 individual enrollees; and

621 b. It is applying this paragraph uniformly to individuals
622 without regard to any health-status-related or preexisting-
623 condition-related factor of such individuals and without regard
624 to whether the individuals are eligible individuals.

625 (b) An issuer, upon denying individual health insurance

626 coverage in any service area in accordance with subparagraph
627 (a)2., may not offer coverage in the individual market within
628 such service area for ~~a period of~~ 180 days after such coverage
629 is denied.

630 (4) (a) ~~(6) (a)~~ A health insurance issuer may deny individual
631 health insurance coverage to an eligible individual if the
632 issuer has demonstrated to the office that:

633 1. It does not have the financial reserves necessary to
634 underwrite additional coverage; and

635 2. It is applying this paragraph uniformly to all
636 individuals in the individual market in this state consistent
637 with the laws of this state and without regard to any health-
638 status-related or preexisting-condition-related factor of such
639 individuals and without regard to whether the individuals are
640 eligible individuals.

641 (b) An issuer, upon denying individual health insurance
642 coverage in any service area in accordance with paragraph (a),
643 may not offer such coverage in the individual market within such
644 service area for ~~a period of~~ 180 days after the date such
645 coverage is denied or until the issuer has demonstrated to the
646 office that the issuer has sufficient financial reserves to
647 underwrite additional coverage, whichever occurs later.

648 (5) (a) ~~(7) (a)~~ Subsection (2) ~~(1)~~ does not require that a
649 health insurance issuer that offers health insurance coverage
650 only in connection with group health plans or through one or

651 more bona fide associations, as defined in s. 627.6571(5), or
652 both, offer such health insurance coverage in the individual
653 market.

654 (b) A health insurance issuer that offers health insurance
655 coverage in connection with group health plans is not deemed to
656 be a health insurance issuer offering individual health
657 insurance coverage solely because such issuer offers a
658 conversion policy.

659 (6) (a) ~~(8)~~ This section does not:

660 ~~(a)~~ restrict the amount of the premium rates that an
661 issuer may charge an individual for individual health insurance
662 coverage, except that the issuer:

663 1. May not establish, under the same individual health
664 insurance coverage, differentials in premium rates that are
665 based on a preexisting condition.

666 2. Shall develop and vary premium rates based only on the
667 factors specified in s. 627.64875.; ~~or~~

668 (b) This section does not prevent a health insurance
669 issuer that offers individual health insurance coverage from
670 establishing premium discounts or rebates or modifying otherwise
671 applicable copayments or deductibles in return for adherence to
672 programs of health promotion and disease prevention.

673 (7) ~~(9)~~ Each health insurance issuer that offers individual
674 health insurance coverage to an eligible individual shall elect
675 to become a risk-assuming carrier or a reinsuring carrier, as

676 provided by s. 627.6475.

677 (8)~~(10)~~ This section applies to individual health
 678 insurance coverage offered on or after January 1, 2021~~1998~~. An
 679 ~~individual who would have been eligible for coverage on July 1,~~
 680 ~~1997, shall be eligible for coverage on January 1, 1998, and~~
 681 ~~shall remain eligible for the same period of time after January~~
 682 ~~1, 1998, that the individual would have remained eligible for~~
 683 ~~coverage after July 1, 1997.~~

684 Section 3. Section 627.64875, Florida Statutes, is created
 685 to read:

686 627.64875 Preexisting conditions; premium rates.—

687 (1) This section establishes protections for those with
 688 preexisting conditions who seek to obtain insurance coverage.

689 (2) As used in this section, the term:

690 (a) "Eligible individual" has the same meaning as defined
 691 in s. 627.6487.

692 (b) "Health insurance issuer" or "issuer" has the same
 693 meaning as defined in s. 627.6487.

694 (c) "Individual health insurance" means health insurance,
 695 as defined in s. 624.603, that is offered to an individual,
 696 including certificates of coverage offered to individuals in
 697 this state as part of a group policy issued to an association
 698 outside this state, but the term does not include excepted
 699 benefits specified in s. 627.6513(1)-(14).

700 (d) "Preexisting condition" has the same meaning as

701 defined in s. 627.6487.

702 (e) "Short-term health insurance" has the same meaning as
703 defined in s. 627.6426.

704 (3) A health insurance issuer that offers an individual
705 health insurance policy in this state may not, with respect to
706 an eligible individual who desires to enroll in individual
707 health insurance coverage:

708 (a) Decline to offer such coverage to, or deny enrollment
709 of, such individual;

710 (b) Impose any preexisting condition exclusion with
711 respect to such coverage; or

712 (c) Establish differentials in premium rates for such
713 coverage based on a preexisting condition.

714 (4) A health insurance issuer that offers an individual
715 health insurance policy shall develop premium rates under the
716 policy based on, and shall vary the rates by, only the following
717 factors:

718 (a) Whether the policy coverage is individual or family
719 coverage.

720 (b) The geographic rating area that is established in
721 accordance with federal law.

722 (c) Age, except that the health insurance issuer may not
723 charge an adult in the oldest age band more than 3 times the
724 rate the issuer charges an adult in the youngest age band for
725 the same coverage.

726 (d) Tobacco use, except that the health insurance issuer
 727 may not charge a tobacco user more than 1 1/15 times the rate
 728 the issuer charges a non-tobacco user for the same coverage.

729
 730 With respect to family coverage under the individual health
 731 insurance policy, an issuer shall apply the rating variations
 732 authorized under this subsection based on the premium
 733 attributable to each family member under such policy in
 734 accordance with commission rules.

735 (5) A health insurance issuer that offers an individual
 736 health insurance policy in this state may not modify the premium
 737 rates for coverages under the policy within 12 months after the
 738 initial issue date or renewal date, unless there is a change:

739 (a) In the geographic rating area that is established in
 740 accordance with federal law;

741 (b) In tobacco use;

742 (c) In family composition if the coverage is family
 743 coverage;

744 (d) In the coverage benefits requested by the eligible
 745 individual; or

746 (e) Due to a requirement by federal law or regulation or
 747 due to an express authorization by state law or rule.

748 (6) This section applies to any health insurance, as
 749 defined in s. 624.603, including short-term health insurance,
 750 that is offered under an individual health insurance policy.

751 This section does not apply to disability income insurance or
752 income replacement insurance coverage.

753 (7) The commission may adopt rules to administer this
754 section and to ensure that rating practices used by health
755 insurance issuers for individual health insurance policies are
756 consistent with the purposes of this section.

757 Section 4. Section 627.65613, Florida Statutes, is created
758 to read:

759 627.65613 Preexisting conditions.—

760 (1) This act establishes protections for those with
761 preexisting conditions who seek to obtain insurance coverage.

762 (2) As used in this section, the term:

763 (a) "Preexisting condition" has the same meaning as
764 defined in s. 627.6487.

765 (b) "Short-term health insurance" has the same meaning as
766 defined in s. 627.6525.

767 (3) An insurer authorized to issue, deliver, issue for
768 delivery, or renew a group, blanket, or franchise health
769 insurance policy in this state may not, with respect to a group,
770 employer, or individual that is eligible to enroll in such
771 policy and that applies for coverage under such policy:

772 (a) Decline to offer such coverage to, or deny enrollment
773 of, such group, employer, or individual; or

774 (b) Impose any preexisting condition exclusion with
775 respect to such coverage.

776 (4) This section applies to any health insurance, as
 777 defined in s. 624.603, including short-term health insurance,
 778 that is offered under a group, blanket, or franchise health
 779 insurance policy. This section does not apply to disability
 780 income insurance or income replacement insurance coverage.

781 (5) The commission may adopt rules to administer this
 782 section.

783 Section 5. Section 627.65614, Florida Statutes, is created
 784 to read:

785 627.65614 Premium rates for franchise health insurance
 786 policies.—

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

788 (a) "Preexisting condition" has the same meaning as
 789 defined in s. 627.6487.

790 (b) "Short-term health insurance" has the same meaning as
 791 defined in s. 627.6525.

792 (2) An insurer authorized to issue, deliver, issue for
 793 delivery, or renew a franchise health insurance policy in this
 794 state may not establish, under such policy, differentials in
 795 premium rates that are based on a preexisting condition. The
 796 insurer shall develop premium rates under the policy based on,
 797 and shall vary the rates by, only the following factors:

798 (a) Whether the policy coverage is individual or family
 799 coverage.

800 (b) The geographic rating area that is established in

801 accordance with federal law.

802 (c) Age, except that the insurer may not charge an adult
803 in the oldest age band more than 3 times the rate the insurer
804 charges an adult in the youngest age band for the same coverage.

805 (d) Tobacco use, except that the insurer may not charge a
806 tobacco user more than 1 1/15 times the rate the insurer charges
807 a non-tobacco user for the same coverage.

808

809 With respect to family coverage under the franchise health
810 insurance policy, an insurer shall apply the rating variations
811 authorized under this subsection based on the premium
812 attributable to each family member in accordance with commission
813 rules.

814 (3) An insurer authorized to issue, deliver, issue for
815 delivery, or renew a franchise health insurance policy in this
816 state may not modify the premium rates for coverages under the
817 policy within 12 months after the initial issue date or renewal
818 date, unless there is a change:

819 (a) In the size, composition, or geographic rating area of
820 the group insured under the franchise health insurance policy;

821 (b) In tobacco use;

822 (c) In family composition if the coverage is family
823 coverage;

824 (d) In the coverage benefits requested by the policyholder
825 or by the group; or

826 (e) Due to a requirement by federal law or regulation or
827 due to an express authorization by state law or rule.

828 (4) This section applies to any health insurance, as
829 defined in s. 624.603, including short-term health insurance,
830 that is offered under a franchise health insurance policy. This
831 section does not apply to disability income insurance or income
832 replacement insurance coverage.

833 (5) The commission may adopt rules to administer this
834 section and to ensure that the rating practices used by insurers
835 for franchise health insurance policies are consistent with the
836 purposes of this section.

837 Section 6. Paragraphs (q) through (w) of subsection (3) of
838 section 627.6699, Florida Statutes, are redesignated as
839 paragraphs (r) through (x), respectively, subsection (2),
840 paragraph (n) of subsection (3), paragraphs (b) through (f) of
841 subsection (5), paragraphs (a) and (b) of subsection (6),
842 paragraphs (b), (d), and (e) of subsection (12), and paragraph
843 (b) of subsection (13) are amended, and a new paragraph (q) is
844 added to subsection (3) of that section, to read:

845 627.6699 Employee Health Care Access Act.—

846 (2) PURPOSE AND INTENT.—The purpose and intent of this
847 section is to promote the availability of health insurance
848 coverage to small employers regardless of their claims
849 experience or their employees' health status or preexisting
850 conditions, to establish rules regarding renewability of that

851 coverage, ~~to establish limitations on the use of exclusions for~~
852 ~~preexisting conditions,~~ to provide for establishment of a
853 reinsurance program for coverage of small employers, and to
854 improve the overall fairness and efficiency of the small group
855 health insurance market.

856 (3) DEFINITIONS.—As used in this section, the term:

857 (n) "Modified community rating" means a method used to
858 develop carrier premiums which spreads financial risk across a
859 large population; allows the use of separate rating factors for
860 age, ~~gender,~~ family composition, tobacco usage, and geographic
861 area as determined under paragraph (5) (f); and allows
862 adjustments for: claims experience, health status, or duration
863 of coverage as permitted under subparagraph (6) (b) 6. ~~(6) (b) 5.~~;
864 and administrative and acquisition expenses as permitted under
865 subparagraph (6) (b) 6. ~~(6) (b) 5.~~

866 (q) "Preexisting condition" has the same meaning as
867 defined in s. 627.6487.

868 (5) AVAILABILITY OF COVERAGE.—

869 (b) Every small employer carrier must, as a condition of
870 transacting business in this state, offer and issue all small
871 employer health benefit plans on a guaranteed-issue basis to
872 every eligible small employer, ~~with 2 to 50 eligible employees,~~
873 that elects to be covered under such plan, agrees to make the
874 required premium payments, and satisfies the other provisions of
875 the plan. A rider for additional or increased benefits may be

876 medically underwritten and may only be added to the standard
877 health benefit plan. The increased rate charged for the
878 additional or increased benefit must be rated in accordance with
879 this section.

880 (c) ~~Except as provided in paragraph (d),~~ A health benefit
881 plan covering small employers must comply with preexisting
882 condition provisions specified in s. 627.65613 ~~s. 627.6561~~ or,
883 for health maintenance contracts, in ss. 641.1855 and 641.31077
884 ~~s. 641.31071~~.

885 (d) A health benefit plan covering small employers, issued
886 or renewed on or after January 1, 2021 ~~1994~~, must ~~comply with~~
887 ~~the following conditions:~~

888 1. ~~All health benefit plans must~~ be offered and issued on
889 a guaranteed-issue basis. Additional or increased benefits may
890 only be offered by riders.

891 2. ~~For health benefit plans that are issued to a small~~
892 ~~employer who has fewer than two employees and that cover an~~
893 ~~employee who has not been continually covered by creditable~~
894 ~~coverage within 63 days before the effective date of the new~~
895 ~~coverage, preexisting condition provisions must not exclude~~
896 ~~coverage for a period beyond 24 months following the employee's~~
897 ~~effective date of coverage and may relate only to:~~

898 a. ~~Conditions that, during the 24-month period immediately~~
899 ~~preceding the effective date of coverage, had manifested~~
900 ~~themselves in such a manner as would cause an ordinarily prudent~~

901 ~~person to seek medical advice, diagnosis, care, or treatment or~~
 902 ~~for which medical advice, diagnosis, care, or treatment was~~
 903 ~~recommended or received; or~~

904 ~~b. A pregnancy existing on the effective date of coverage.~~

905 (e) All health benefit plans issued under this section
 906 must comply with the following conditions:

907 1. For employers who have fewer than two employees, a late
 908 enrollee may be excluded from coverage for no longer than 24
 909 months if he or she was not covered by creditable coverage
 910 continually to a date not more than 63 days before the effective
 911 date of his or her new coverage.

912 2. Any requirement used by a small employer carrier in
 913 determining whether to provide coverage to a small employer
 914 group, including requirements for minimum participation of
 915 eligible employees and minimum employer contributions, must be
 916 applied uniformly among all small employer groups having the
 917 same number of eligible employees applying for coverage or
 918 receiving coverage from the small employer carrier, ~~except that~~
 919 ~~a small employer carrier that participates in, administers, or~~
 920 ~~issues health benefits pursuant to s. 381.0406 which do not~~
 921 ~~include a preexisting condition exclusion may require as a~~
 922 ~~condition of offering such benefits that the employer has had no~~
 923 ~~health insurance coverage for its employees for a period of at~~
 924 ~~least 6 months.~~ A small employer carrier may vary application of
 925 minimum participation requirements and minimum employer

926 contribution requirements only by the size of the small employer
927 group.

928 3. In applying minimum participation requirements with
929 respect to a small employer, a small employer carrier shall not
930 consider as an eligible employee employees or dependents who
931 have qualifying existing coverage in an employer-based group
932 insurance plan or an ERISA qualified self-insurance plan in
933 determining whether the applicable percentage of participation
934 is met. However, a small employer carrier may count eligible
935 employees and dependents who have coverage under another health
936 plan that is sponsored by that employer.

937 4. A small employer carrier shall not increase any
938 requirement for minimum employee participation or any
939 requirement for minimum employer contribution applicable to a
940 small employer at any time after the small employer has been
941 accepted for coverage, unless the employer size has changed, in
942 which case the small employer carrier may apply the requirements
943 that are applicable to the new group size.

944 5. If a small employer carrier offers coverage to a small
945 employer, it must offer coverage to all the small employer's
946 eligible employees and their dependents. A small employer
947 carrier may not offer coverage limited to certain persons in a
948 group or to part of a group, except with respect to late
949 enrollees.

950 6. A small employer carrier may not modify any health

951 benefit plan issued to a small employer with respect to a small
952 employer or any eligible employee or dependent through riders,
953 endorsements, or otherwise to restrict or exclude coverage for
954 certain diseases or medical conditions otherwise covered by the
955 health benefit plan.

956 7. An initial enrollment period of at least 30 days must
957 be provided. An annual 30-day open enrollment period must be
958 offered to each small employer's eligible employees and their
959 dependents. A small employer carrier must provide special
960 enrollment periods as required by s. 627.65615.

961 (f) The boundaries of geographic areas used by a small
962 employer carrier must coincide with county lines. A carrier may
963 not apply different geographic rating factors to the rates of
964 small employers located within the same county or within the
965 same geographic rating area that is established in accordance
966 with federal law.

967 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

968 (a) The commission may, by rule, establish regulations to
969 administer this section and to ensure ~~assure~~ that rating
970 practices used by small employer carriers are consistent with
971 the purpose of this section, including ensuring ~~assuring~~ that
972 differences in rates charged for health benefit plans by small
973 employer carriers are reasonable and reflect objective
974 differences in plan design, not including differences due to the
975 nature of the groups assumed to select particular health benefit

976 plans.

977 (b) For all small employer health benefit plans that are
978 subject to this section and issued by small employer carriers on
979 or after January 1, 2021 ~~1994~~, premium rates for health benefit
980 plans are subject to the following:

981 1. A small employer carrier may not vary premium rates
982 based on one or more preexisting conditions. A small employer
983 carrier ~~carriers~~ must use a modified community rating
984 methodology in which the premium for each small employer is
985 determined solely on the basis of the eligible employee's and
986 eligible dependent's ~~gender~~, age, family composition, tobacco
987 use, or geographic area as determined under paragraph (5)(f) and
988 in which the premium may be adjusted as permitted by this
989 paragraph. A small employer carrier:

990 a. May not charge an adult in the oldest age band more
991 than 3 times the rate the small employer carrier charges an
992 adult in the youngest age band under the same health benefit
993 plan.

994 b. May not charge a tobacco user more than 1 1/15 times
995 the rate the small employer carrier charges a non-tobacco user
996 under the same health benefit plan.

997 c. Must, with respect to family coverage, apply the rating
998 variations authorized under this subparagraph based on the
999 premium attributable to each family member under the health
1000 benefit plan in accordance with commission rules ~~is not required~~

1001 ~~to use gender as a rating factor for a nongrandfathered health~~
 1002 ~~plan.~~

1003 2. Rating factors related to age, ~~gender,~~ family
 1004 composition, tobacco use, or geographic location may be
 1005 developed by each carrier to reflect the carrier's experience.
 1006 The factors used by carriers are subject to office review and
 1007 approval.

1008 3. Except as provided in subparagraph 4., a small employer
 1009 carrier ~~carriers~~ may not modify the rate for a small employer or
 1010 an eligible employee within ~~for~~ 12 months after ~~from~~ the initial
 1011 issue date or renewal date, unless there is a change:

1012 a. In the group's size, composition, or geographic rating
 1013 area as established in accordance with federal law; ~~of the group~~

1014 b. In tobacco use;

1015 c. In family composition if the eligible employee's
 1016 coverage is family coverage;

1017 d. In the coverage benefits requested by the eligible
 1018 employee or the small employer; or

1019 e. Due to a requirement by federal law or regulation or
 1020 due to an express authorization by state law or rule ~~changes or~~
 1021 ~~benefits are changed.~~

1022 4. ~~However,~~ A small employer carrier may modify the rate
 1023 one time within the 12 months after the initial issue date for a
 1024 small employer who enrolls under a previously issued group
 1025 policy that has a common anniversary date for all employers

HB 1293

2020

1026 covered under the policy if:

1027 a. The carrier discloses to the employer in a clear and
1028 conspicuous manner the date of the first renewal and the fact
1029 that the premium may increase on or after that date.

1030 b. The insurer demonstrates to the office that
1031 efficiencies in administration are achieved and reflected in the
1032 rates charged to small employers covered under the policy.

1033 ~~5.4.~~ A carrier may issue a group health insurance policy
1034 to a small employer health alliance or other group association
1035 with rates that reflect a premium credit for expense savings
1036 attributable to administrative activities being performed by the
1037 alliance or group association if such expense savings are
1038 specifically documented in the insurer's rate filing and are
1039 approved by the office. Any such credit may not be based on
1040 different morbidity assumptions or on any other factor related
1041 to the health status, preexisting conditions, or claims
1042 experience of any person covered under the policy. This
1043 subparagraph does not exempt an alliance or group association
1044 from licensure for activities that require licensure under the
1045 insurance code. A carrier issuing a group health insurance
1046 policy to a small employer health alliance or other group
1047 association shall allow any properly licensed and appointed
1048 agent of that carrier to market and sell the small employer
1049 health alliance or other group association policy. Such agent
1050 shall be paid the usual and customary commission paid to any

1051 agent selling the policy.

1052 ~~6.5~~ Any adjustments in rates for claims experience,
1053 health status, or duration of coverage may not be charged to
1054 individual employees or dependents. For a small employer's
1055 policy, such adjustments may not result in a rate for the small
1056 employer which deviates more than 15 percent from the carrier's
1057 approved rate. Any such adjustment must be applied uniformly to
1058 the rates charged for all employees and dependents of the small
1059 employer. A small employer carrier may make an adjustment to a
1060 small employer's renewal premium, up to 10 percent annually, due
1061 to the claims experience, health status, or duration of coverage
1062 of the employees or dependents of the small employer. If the
1063 aggregate resulting from the application of such adjustment
1064 exceeds the premium that would have been charged by application
1065 of the approved modified community rate by 4 percent for the
1066 current policy term, the carrier shall limit the application of
1067 such adjustments only to minus adjustments. For any subsequent
1068 policy term, if the total aggregate adjusted premium actually
1069 charged does not exceed the premium that would have been charged
1070 by application of the approved modified community rate by 4
1071 percent, the carrier may apply both plus and minus adjustments.
1072 A small employer carrier may provide a credit to a small
1073 employer's premium based on administrative and acquisition
1074 expense differences resulting from the size of the group. Group
1075 size administrative and acquisition expense factors may be

1076 developed by each carrier to reflect the carrier's experience
1077 and are subject to office review and approval.

1078 ~~7.6.~~ A small employer carrier rating methodology may
1079 include separate rating categories for one dependent child, for
1080 two dependent children, and for three or more dependent children
1081 for family coverage of employees having a spouse and dependent
1082 children or employees having dependent children only. A small
1083 employer carrier may have fewer, but not greater, numbers of
1084 categories for dependent children than those specified in this
1085 subparagraph.

1086 ~~8.7.~~ Small employer carriers may not use a composite
1087 rating methodology to rate a small employer ~~with fewer than 10~~
1088 ~~employees~~. For the purposes of this subparagraph, the term
1089 "composite rating methodology" means a rating methodology that
1090 averages the impact of the rating factors for age and gender in
1091 the premiums charged to all of the employees of a small
1092 employer.

1093 ~~9.8.~~ A carrier may separate the experience of small
1094 employer groups with fewer than 2 eligible employees from the
1095 experience of small employer groups with 2-50 eligible employees
1096 for purposes of determining an alternative modified community
1097 rating.

1098 a. If a carrier separates the experience of small employer
1099 groups, the rate to be charged to small employer groups of fewer
1100 than 2 eligible employees may not exceed 150 percent of the rate

1101 determined for small employer groups of 2-50 eligible employees.
1102 However, the carrier may charge excess losses of the experience
1103 pool consisting of small employer groups with fewer ~~less~~ than 2
1104 eligible employees to the experience pool consisting of small
1105 employer groups with 2-50 eligible employees so that all losses
1106 are allocated and the 150-percent rate limit on the experience
1107 pool consisting of small employer groups with fewer ~~less~~ than 2
1108 eligible employees is maintained.

1109 b. Notwithstanding s. 627.411(1), the rate to be charged
1110 to a small employer group of fewer than 2 eligible employees,
1111 ~~insured as of July 1, 2002,~~ may be up to 125 percent of the rate
1112 determined for small employer groups of 2-50 eligible employees
1113 for the first annual renewal and 150 percent for subsequent
1114 annual renewals.

1115 ~~10.9.~~ A carrier shall separate the experience of
1116 grandfathered health plans from nongrandfathered health plans
1117 for determining rates.

1118 (12) STANDARDS TO ENSURE ~~ASSURE~~ FAIR MARKETING.—

1119 (b) A small employer carrier or agent shall not, directly
1120 or indirectly, engage in the following activities:

1121 1. Encouraging or directing small employers to refrain
1122 from filing an application for coverage with the small employer
1123 carrier because of the health status, preexisting condition,
1124 claims experience, industry, occupation, or geographic location
1125 of the small employer.

1126 2. Encouraging or directing small employers to seek
1127 coverage from another carrier because of the health status,
1128 preexisting condition, claims experience, industry, occupation,
1129 or geographic location of the small employer.

1130 (d) A small employer carrier shall not, directly or
1131 indirectly, enter into any contract, agreement, or arrangement
1132 with an agent that provides for or results in the compensation
1133 paid to an agent for the sale of a health benefit plan to be
1134 varied because of the health status, preexisting condition,
1135 claims experience, industry, occupation, or geographic location
1136 of the small employer except if the compensation arrangement
1137 provides compensation to an agent on the basis of percentage of
1138 premium, provided that the percentage shall not vary because of
1139 the health status, preexisting condition, claims experience,
1140 industry, occupation, or geographic area of the small employer.

1141 (e) A small employer carrier shall not terminate, fail to
1142 renew, or limit its contract or agreement of representation with
1143 an agent for any reason related to the health status,
1144 preexisting condition, claims experience, occupation, or
1145 geographic location of the small employers placed by the agent
1146 with the small employer carrier unless the agent consistently
1147 engages in practices that violate this section or s. 626.9541.

1148 (13) DISCLOSURE OF INFORMATION.—

1149 (b)1. Subject to subparagraph 3., with respect to a small
1150 employer carrier that offers a health benefit plan to a small

1151 employer, information described in this paragraph is information
 1152 that concerns:

1153 a. The provisions of such coverage concerning an insurer's
 1154 right to change premium rates and the factors that may affect
 1155 changes in premium rates;

1156 b. The provisions of such coverage that relate to
 1157 renewability of coverage;

1158 ~~e. The provisions of such coverage that relate to any~~
 1159 ~~preexisting condition exclusions;~~ and

1160 c.d. The benefits and premiums available under all health
 1161 insurance coverage for which the employer is qualified.

1162 2. Information required under this subsection shall be
 1163 provided to small employers in a manner determined to be
 1164 understandable by the average small employer, and shall be
 1165 sufficient to reasonably inform small employers of their rights
 1166 and obligations under the health insurance coverage.

1167 3. An insurer is not required under this subsection to
 1168 disclose any information that is proprietary or a trade secret
 1169 under state law.

1170 Section 7. Section 641.1855, Florida Statutes, is created
 1171 to read:

1172 641.1855 Premium rates for individual and small employer
 1173 health maintenance contracts.—

1174 (1) As used in this section, the term:

1175 (a) "Health maintenance contract" means a health

1176 maintenance contract offered in the individual market, a health
1177 maintenance contract that is individually underwritten, or a
1178 health maintenance contract provided to a small employer.

1179 (b) "Preexisting condition" has the same meaning as
1180 defined in s. 641.31077.

1181 (c) "Short-term health insurance" has the same meaning as
1182 defined in 641.31077.

1183 (2) A health maintenance organization that offers a health
1184 maintenance contract in this state may not establish, under such
1185 contract, differentials in premium rates that are based on a
1186 preexisting condition. The health maintenance organization shall
1187 develop premium rates under the contract based on, and shall
1188 vary the rates by, only the following factors:

1189 (a) Whether the contract coverage is individual or family
1190 coverage.

1191 (b) The geographic rating area that is established in
1192 accordance with federal law.

1193 (c) Age, except that the health maintenance organization
1194 may not charge an adult in the oldest age band more than 3 times
1195 the rate the health maintenance organization charges an adult in
1196 the youngest age band for the same coverage.

1197 (d) Tobacco use, except that the health maintenance
1198 organization may not charge a tobacco user more than 1 1/15
1199 times the rate the health maintenance organization charges a
1200 non-tobacco user for the same coverage.

1201
1202 With respect to family coverage under the health maintenance
1203 contract, a health maintenance organization shall apply the
1204 rating variations authorized under this subsection based on the
1205 premium attributable to each family member in accordance with
1206 commission rules.

1207 (3) A health maintenance organization that offers a health
1208 maintenance contract in this state may not modify the premium
1209 rates for coverages under the health maintenance contract within
1210 12 months after the initial issue date or renewal date, unless
1211 there is a change:

1212 (a) In the individual contract holder's geographic rating
1213 area if the contract is an individual health maintenance
1214 contract, or in the small employer's size, composition, or
1215 geographic rating area established in accordance with federal
1216 law if the contract is a small employer health maintenance
1217 contract;

1218 (b) In tobacco use;

1219 (c) In family composition if the coverage is family
1220 coverage;

1221 (d) In the coverage benefits requested by the contract
1222 holder or by the small employer; or

1223 (e) Due to a requirement by federal law or regulation or
1224 due to an express authorization by state law or rule.

1225 (4) This section applies to any health insurance, as

1226 defined in s. 624.603, including short-term health insurance,
1227 that is offered under a health maintenance contract. This
1228 section does not apply to disability income insurance or income
1229 replacement insurance coverage.

1230 Section 8. Section 641.31077, Florida Statutes, is created
1231 to read:

1232 641.31077 Preexisting conditions.—

1233 (1) This act establishes protections for those with
1234 preexisting conditions who seek to obtain insurance coverage.

1235 (2) As used in this section, the term:

1236 (a) "Preexisting condition" means a condition that existed
1237 before the effective date of health maintenance coverage or the
1238 date of the coverage denial, regardless of whether any medical
1239 advice, diagnosis, care, or treatment was recommended or
1240 received for such condition before that date.

1241 (b) "Short-term health insurance" means a health
1242 maintenance contract with an expiration date specified in the
1243 contract that is less than 12 months after the original
1244 effective date of the contract and, taking into account renewals
1245 or extensions, has a duration not to exceed 36 months in total.

1246 (3) A health maintenance organization issuing or
1247 delivering an individual or group health maintenance contract in
1248 this state may not, with respect to a group, an employer, or an
1249 individual that is eligible to enroll for coverage under such
1250 contract and that applies for coverage under such contract:

1251 (a) Decline to offer such coverage to, or deny enrollment
 1252 of, such group, employer, or individual; or

1253 (b) Impose any preexisting condition exclusion with
 1254 respect to such coverage.

1255 (4) This section applies to any health insurance, as
 1256 defined in s. 624.603, including short-term health insurance,
 1257 that is offered under an individual or group health maintenance
 1258 contract. This section does not apply to disability income
 1259 insurance or income replacement insurance coverage.

1260 Section 9. Paragraph (a) of subsection (4) of section
 1261 408.9091, Florida Statutes, is amended to read:

1262 408.9091 Cover Florida Health Care Access Program.—

1263 (4) PROGRAM.—The agency and the office shall jointly
 1264 establish and administer the Cover Florida Health Care Access
 1265 Program.

1266 (a) General Cover Florida plan components must require
 1267 that:

1268 1. Plans are offered on a guaranteed-issue basis to
 1269 enrollees, ~~subject to exclusions for preexisting conditions~~
 1270 ~~approved by the office and the agency.~~

1271 2. Plans are portable such that the enrollee remains
 1272 covered regardless of employment status or the cost sharing of
 1273 premiums.

1274 3. Plans provide for cost containment through limits on
 1275 the number of services, caps on benefit payments, and copayments

1276 | for services.

1277 | 4. A Cover Florida plan entity makes all benefit plan and
1278 | marketing materials available in English and Spanish.

1279 | 5. In order to provide for consumer choice, Cover Florida
1280 | plan entities develop two alternative benefit option plans
1281 | having different cost and benefit levels, including at least one
1282 | plan that provides catastrophic coverage.

1283 | 6. Plans without catastrophic coverage provide coverage
1284 | options for services including, but not limited to:

1285 | a. Preventive health services, including immunizations,
1286 | annual health assessments, well-woman and well-care services,
1287 | and preventive screenings such as mammograms, cervical cancer
1288 | screenings, and noninvasive colorectal or prostate screenings.

1289 | b. Incentives for routine preventive care.

1290 | c. Office visits for the diagnosis and treatment of
1291 | illness or injury.

1292 | d. Office surgery, including anesthesia.

1293 | e. Behavioral health services.

1294 | f. Durable medical equipment and prosthetics.

1295 | g. Diabetic supplies.

1296 | 7. Plans providing catastrophic coverage, at a minimum,
1297 | provide coverage options for all of the services listed under
1298 | subparagraph 6.; however, such plans may include, but are not
1299 | limited to, coverage options for:

1300 | a. Inpatient hospital stays.

1301 b. Hospital emergency care services.

1302 c. Urgent care services.

1303 d. Outpatient facility services, outpatient surgery, and

1304 outpatient diagnostic services.

1305 8. All plans offer prescription drug benefit coverage, use

1306 a prescription drug manager, or offer a discount drug card.

1307 9. Plan enrollment materials provide information in plain

1308 language on policy benefit coverage, benefit limits, cost-

1309 sharing requirements, and exclusions and a clear representation

1310 of what is not covered in the plan. Such enrollment materials

1311 must include a standard disclosure form adopted by rule by the

1312 Financial Services Commission, to be reviewed and executed by

1313 all consumers purchasing Cover Florida plan coverage.

1314 10. Plans offered through a qualified employer meet the

1315 requirements of s. 125 of the Internal Revenue Code.

1316 Section 10. Subsection (5) of section 409.814, Florida

1317 Statutes, is amended to read:

1318 409.814 Eligibility.—A child who has not reached 19 years

1319 of age whose family income is equal to or below 200 percent of

1320 the federal poverty level is eligible for the Florida Kidcare

1321 program as provided in this section. If an enrolled individual

1322 is determined to be ineligible for coverage, he or she must be

1323 immediately disenrolled from the respective Florida Kidcare

1324 program component.

1325 ~~(5) A child who is otherwise eligible for the Florida~~

1326 ~~Kidcare program and who has a preexisting condition that~~
 1327 ~~prevents coverage under another insurance plan as described in~~
 1328 ~~paragraph (4) (a) which would have disqualified the child for the~~
 1329 ~~Florida Kidcare program if the child were able to enroll in the~~
 1330 ~~plan is eligible for Florida Kidcare coverage when enrollment is~~
 1331 ~~possible.~~

1332 Section 11. Subsection (3) of section 409.816, Florida
 1333 Statutes, is amended to read:

1334 409.816 Limitations on premiums and cost sharing.—The
 1335 following limitations on premiums and cost sharing are
 1336 established for the program.

1337 (3) Enrollees in families with a family income above 150
 1338 percent of the federal poverty level who are not receiving
 1339 coverage under the Medicaid program or who are not eligible
 1340 under s. 409.814(5) ~~s. 409.814(6)~~ may be required to pay
 1341 enrollment fees, premiums, copayments, deductibles, coinsurance,
 1342 or similar charges on a sliding scale related to income, except
 1343 that the total annual aggregate cost sharing with respect to all
 1344 children in a family may not exceed 5 percent of the family's
 1345 income. However, copayments, deductibles, coinsurance, or
 1346 similar charges may not be imposed for preventive services,
 1347 including well-baby and well-child care, age-appropriate
 1348 immunizations, and routine hearing and vision screenings.

1349 Section 12. Paragraph (b) of subsection (5) of section
 1350 627.429, Florida Statutes, is amended to read:

1351 627.429 Medical tests for HIV infection and AIDS for
1352 insurance purposes.—

1353 (5) RESTRICTIONS ON COVERAGE EXCLUSIONS AND LIMITATIONS.—

1354 (b) Subject to the total benefits limits in a health
1355 insurance policy, no health insurance policy shall contain an
1356 exclusion or limitation with respect to coverage for exposure to
1357 the HIV infection or a specific sickness or medical condition
1358 derived from such infection, ~~except as provided in a preexisting~~
1359 ~~condition clause~~. This paragraph does not prohibit the issuance
1360 of accident-only or specified disease health policies.

1361 Section 13. Subsection (2) of section 627.607, Florida
1362 Statutes, is amended to read:

1363 627.607 Time limit on certain defenses.—

1364 (2) A policy may, in place of the provision set forth in
1365 subsection (1), include the following provision:

1366 "Incontestable:

1367 ~~(a)~~ Misstatements in the Application: After this policy
1368 has been in force for 2 years during the insured's lifetime
1369 (excluding any period during which the insured is disabled), the
1370 insurer cannot contest the statements in the application.

1371 ~~(b) Preexisting Conditions: No claim for loss incurred or~~
1372 ~~disability starting after 2 years from the issue date will be~~
1373 ~~reduced or denied because a sickness or physical condition, not~~
1374 ~~excluded by name or specific description before the date of~~
1375 ~~loss, had existed before the effective date of coverage."~~

1376 Section 14. Subsection (1) of section 627.6415, Florida
 1377 Statutes, is amended to read:

1378 627.6415 Coverage for natural-born, adopted, and foster
 1379 children; children in insured's custodial care.—

1380 (1) A health insurance policy that provides coverage for a
 1381 member of the family of the insured shall, as to the family
 1382 member's coverage, provide that the health insurance benefits
 1383 applicable to children of the insured also apply to an adopted
 1384 child or a foster child of the insured placed in compliance with
 1385 chapter 63, before ~~prior to~~ the child's 18th birthday, from the
 1386 moment of placement in the residence of the insured. ~~Except in~~
 1387 ~~the case of a foster child,~~ The policy may not exclude coverage
 1388 for any preexisting condition of the child. In the case of a
 1389 newborn child, coverage begins at the moment of birth if a
 1390 written agreement to adopt the child has been entered into by
 1391 the insured before ~~prior to~~ the birth of the child, whether or
 1392 not the agreement is enforceable. This section does not require
 1393 coverage for an adopted child who is not ultimately placed in
 1394 the residence of the insured in compliance with chapter 63.

1395 Section 15. Paragraph (c) of subsection (2) of section
 1396 627.642, Florida Statutes, is amended to read:

1397 627.642 Outline of coverage.—

1398 (2) The outline of coverage shall contain:

1399 (c) A summary statement of the principal exclusions and
 1400 limitations or reductions contained in the policy, including,

1401 but not limited to, ~~preexisting conditions~~, probationary
 1402 periods, elimination periods, deductibles, coinsurance, and any
 1403 age limitations or reductions.

1404 Section 16. Paragraphs (d) and (e) of subsection (2) and
 1405 paragraph (a) of subsection (3) of section 627.6425, Florida
 1406 Statutes, are amended to read:

1407 627.6425 Renewability of individual coverage.—

1408 (2) An insurer may nonrenew or discontinue health
 1409 insurance coverage of an individual in the individual market
 1410 based only on one or more of the following:

1411 (d) In the case of a health insurer that offers health
 1412 insurance coverage in the market through a network plan, the
 1413 individual no longer resides, lives, or works in the service
 1414 area, or in an area for which the insurer is authorized to do
 1415 business, but only if such coverage is terminated under this
 1416 paragraph uniformly without regard to any health-status-related
 1417 or preexisting-condition-related factor of covered individuals.
 1418 As used in this section, the term "preexisting condition" has
 1419 the same meaning as defined in s. 627.6487.

1420 (e) In the case of health insurance coverage that is made
 1421 available in the individual market only through one or more bona
 1422 fide associations, as defined in s. 627.6571(5), the membership
 1423 of the individual in the association, on the basis of which the
 1424 coverage is provided, ceases, but only if such coverage is
 1425 terminated under this paragraph uniformly without regard to any

1426 health-status-related or preexisting-condition-related factor of
1427 covered individuals.

1428 (3) (a) If an insurer decides to discontinue offering a
1429 particular policy form for health insurance coverage offered in
1430 the individual market, coverage under such form may be
1431 discontinued by the insurer only if:

1432 1. The insurer provides notice to each covered individual
1433 provided coverage under this policy form in the individual
1434 market of such discontinuation at least 90 days before the date
1435 of the nonrenewal of such coverage;

1436 2. The insurer offers to each individual in the individual
1437 market provided coverage under this policy form the option to
1438 purchase any other individual health insurance coverage
1439 currently being offered by the insurer for individuals in such
1440 market in the state; and

1441 3. In exercising the option to discontinue coverage of a
1442 policy form and in offering the option of coverage under
1443 subparagraph 2., the insurer acts uniformly without regard to
1444 any health-status-related or preexisting-condition-related
1445 factor of enrolled individuals or individuals who may become
1446 eligible for such coverage. If a policy form covers both
1447 grandfathered and nongrandfathered health plans, an insurer may
1448 nonrenew coverage only for the nongrandfathered health plans, in
1449 which case the requirements of subparagraphs 1. and 2. apply
1450 only to the nongrandfathered health plans. As used in this

1451 subparagraph, the terms "grandfathered health plan" and
 1452 "nongrandfathered health plan" have the same meaning as provided
 1453 in s. 627.402.

1454 Section 17. Subsection (2) of section 627.6426, Florida
 1455 Statutes, is amended to read:

1456 627.6426 Short-term health insurance.—

1457 (2) All contracts for short-term health insurance entered
 1458 into by an issuer and an individual seeking coverage shall
 1459 include the following disclosure:

1460
 1461 "This coverage is not required to comply with certain federal
 1462 market requirements for health insurance, principally those
 1463 contained in the Patient Protection and Affordable Care Act. Be
 1464 sure to check your policy carefully to make sure you are aware
 1465 of any exclusions or limitations regarding coverage of
 1466 ~~preexisting conditions or~~ health benefits (such as
 1467 hospitalization, emergency services, maternity care, preventive
 1468 care, prescription drugs, and mental health and substance use
 1469 disorder services). Your policy might also have lifetime and/or
 1470 annual dollar limits on health benefits. If this coverage
 1471 expires or you lose eligibility for this coverage, you might
 1472 have to wait until an open enrollment period to get other health
 1473 insurance coverage."

1474 Section 18. Paragraphs (b) and (e) of subsection (2) of
 1475 section 627.6475, Florida Statutes, are amended to read:

1476 627.6475 Individual reinsurance pool.—
 1477 (2) DEFINITIONS.—As used in this section:
 1478 (b) "Health insurance issuer," "issuer," and "individual
 1479 health insurance" have the same meaning as defined in s.
 1480 627.6487 ~~ascribed in s. 627.6487(2).~~
 1481 (e) "Eligible individual" has the same meaning as defined
 1482 in s. 627.6487 ~~ascribed in s. 627.6487(3).~~
 1483 Section 19. Section 627.6512, Florida Statutes, is amended
 1484 to read:
 1485 627.6512 Exemption of certain group health insurance
 1486 policies.—Sections ~~627.6561~~, 627.65615, 627.65625, and 627.6571
 1487 do not apply to any group insurance policy in relation to its
 1488 provision of benefits described in s. 627.6513(1)-(14).
 1489 Section 20. Subsection (2) of section 627.6525, Florida
 1490 Statutes, is amended to read:
 1491 627.6525 Short-term health insurance.—
 1492 (2) All contracts for short-term health insurance entered
 1493 into by an issuer and a party seeking coverage shall include the
 1494 following disclosure:
 1495 "This coverage is not required to comply with certain federal
 1496 market requirements for health insurance, principally those
 1497 contained in the Patient Protection and Affordable Care Act. Be
 1498 sure to check your policy carefully to make sure you are aware
 1499 of any exclusions or limitations regarding coverage of
 1500 ~~preexisting conditions or~~ health benefits (such as

1501 hospitalization, emergency services, maternity care, preventive
 1502 care, prescription drugs, and mental health and substance use
 1503 disorder services). Your policy might also have lifetime and/or
 1504 annual dollar limits on health benefits. If this coverage
 1505 expires or you lose eligibility for this coverage, you might
 1506 have to wait until an open enrollment period to get other health
 1507 insurance coverage."

1508 Section 21. Section 627.65625, Florida Statutes, is
 1509 amended to read:

1510 627.65625 Prohibiting discrimination against individual
 1511 participants and beneficiaries based on health status or
 1512 preexisting conditions.—

1513 (1) Subject to subsection (2), an insurer that offers a
 1514 group health insurance policy may not establish rules for
 1515 eligibility, including continued eligibility, of an individual
 1516 to enroll under the terms of the policy based on any of the
 1517 following health-status-related or preexisting-condition-related
 1518 factors in relation to the individual or a dependent of the
 1519 individual:

- 1520 (a) Health status.
- 1521 (b) Medical condition, including physical and mental
 1522 illnesses.
- 1523 (c) Claims experience.
- 1524 (d) Receipt of health care.
- 1525 (e) Medical history.

- 1526 (f) Genetic information.
- 1527 (g) Evidence of insurability, including conditions arising
- 1528 out of acts of domestic violence.
- 1529 (h) Disability.
- 1530 (i) Preexisting condition.

1531

1532 As used in this section, the term "preexisting condition" has

1533 the same meaning as defined in s. 627.6487.

1534 (2) Subsection (1) does not:

1535 (a) Require an insurer to provide particular benefits

1536 other than those provided under the terms of such plan or

1537 coverage.

1538 (b) Prevent such a plan or coverage from establishing

1539 limitations or restrictions on the amount, level, extent, or

1540 nature of the benefits or coverage for similarly situated

1541 individuals enrolled in the plan or coverage.

1542 (3) For purposes of subsection (1), rules for eligibility

1543 to enroll under a policy include rules for defining any

1544 applicable waiting periods of enrollment.

1545 (4) (a) An insurer that offers health insurance coverage

1546 may not require any individual, as a condition of enrollment or

1547 continued enrollment under the policy, to pay a premium or

1548 contribution that is greater than such premium or contribution

1549 for a similarly situated individual enrolled under the policy on

1550 the basis of any health-status-related or preexisting-condition-

1551 related factor in relation to the individual or to an individual
 1552 enrolled under the policy as a dependent of the individual.

1553 (b) This subsection does not:

1554 1. Restrict the amount that an employer may be charged for
 1555 coverage under a group health insurance policy; or

1556 2. Prevent an insurer that offers group health insurance
 1557 coverage from establishing premium discounts or rebates or
 1558 modifying otherwise applicable copayments or deductibles in
 1559 return for adherence to programs of health promotion and disease
 1560 prevention.

1561 Section 22. Paragraph (f) of subsection (2), paragraph (a)
 1562 of subsection (3), and subsection (5) of section 627.6571,
 1563 Florida Statutes, are amended to read:

1564 627.6571 Guaranteed renewability of coverage.—

1565 (2) An insurer may nonrenew or discontinue a group health
 1566 insurance policy based only on one or more of the following
 1567 conditions:

1568 (f) In the case of health insurance coverage that is made
 1569 available only through one or more bona fide associations as
 1570 defined in subsection (5) or through one or more small employer
 1571 health alliances as described in s. 627.654(1)(b), the
 1572 membership of an employer in the association or in the small
 1573 employer health alliance, on the basis of which the coverage is
 1574 provided, ceases, but only if such coverage is terminated under
 1575 this paragraph uniformly without regard to any health-status-

1576 related or preexisting-condition-related factor that relates to
1577 any covered individuals. As used in this section, the term
1578 "preexisting condition" has the same meaning as defined in s.
1579 627.6487.

1580 (3) (a) An insurer may discontinue offering a particular
1581 policy form of group health insurance coverage offered in the
1582 small-group market or large-group market only if:

1583 1. The insurer provides notice to each policyholder
1584 provided coverage under this policy form, and to participants
1585 and beneficiaries covered under such coverage, of such
1586 discontinuation at least 90 days before the date of the
1587 nonrenewal of such coverage;

1588 2. The insurer offers to each policyholder provided
1589 coverage under this policy form the option to purchase all, or
1590 in the case of the large-group market, any other health
1591 insurance coverage currently being offered by the insurer in
1592 such market; and

1593 3. In exercising the option to discontinue coverage of
1594 this form and in offering the option of coverage under
1595 subparagraph 2., the insurer acts uniformly without regard to
1596 the claims experience of those policyholders or any health-
1597 status-related or preexisting-condition-related factor that
1598 relates to any participants or beneficiaries covered or new
1599 participants or beneficiaries who may become eligible for such
1600 coverage. If a policy form covers both grandfathered and

1601 nongrandfathered health plans, an insurer may nonrenew coverage
1602 only for nongrandfathered health plans, in which case the
1603 requirements of subparagraphs 1. and 2. apply only to the
1604 nongrandfathered health plans. As used in this subparagraph, the
1605 terms "grandfathered health plan" and "nongrandfathered health
1606 plan" have the same meanings as provided in s. 627.402.

1607 (5) As used in this section, the term "bona fide
1608 association" means an association that:

1609 (a) Has been actively in existence for at least 5 years;

1610 (b) Has been formed and maintained in good faith for
1611 purposes other than obtaining insurance;

1612 (c) Does not condition membership in the association on
1613 any health-status-related or preexisting-condition-related
1614 factor that relates to an individual, including an employee of
1615 an employer or a dependent of an employee;

1616 (d) Makes health insurance coverage offered through the
1617 association available to all members regardless of any health-
1618 status-related or preexisting-condition-related factor that
1619 relates to such members or individuals eligible for coverage
1620 through a member; and

1621 (e) Does not make health insurance coverage offered
1622 through the association available other than in connection with
1623 a member of the association.

1624 Section 23. Subsection (1) of section 627.6578, Florida
1625 Statutes, is amended to read:

1626 627.6578 Coverage for natural-born, adopted, and foster
 1627 children; children in insured's custodial care.—
 1628 (1) A group, blanket, or franchise health insurance policy
 1629 that provides coverage for a family member of the
 1630 certificateholder or subscriber shall, as to such family
 1631 member's coverage, provide that benefits applicable to children
 1632 of the certificateholder or subscriber also apply to an adopted
 1633 child or a foster child of the certificateholder or subscriber
 1634 placed in compliance with chapter 63, from the moment of
 1635 placement in the residence of the certificateholder or
 1636 subscriber. ~~Except in the case of a foster child,~~ The policy may
 1637 not exclude coverage for any preexisting condition of the child.
 1638 In the case of a newborn child, coverage begins at the moment of
 1639 birth if a written agreement to adopt such child has been
 1640 entered into by the certificateholder or subscriber before ~~prior~~
 1641 ~~to~~ the birth of the child, whether or not the agreement is
 1642 enforceable. This section does not require coverage for an
 1643 adopted child who is not ultimately placed in the residence of
 1644 the certificateholder or subscriber in compliance with chapter
 1645 63.
 1646 Section 24. Subsections (10) through (20) of section
 1647 627.6675, Florida Statutes, are renumbered as subsections (9)
 1648 through (19), respectively, and subsection (9) and present
 1649 subsection (15) of that section are amended to read:
 1650 627.6675 Conversion on termination of eligibility.—Subject

1651 to all of the provisions of this section, a group policy
1652 delivered or issued for delivery in this state by an insurer or
1653 nonprofit health care services plan that provides, on an
1654 expense-incurred basis, hospital, surgical, or major medical
1655 expense insurance, or any combination of these coverages, shall
1656 provide that an employee or member whose insurance under the
1657 group policy has been terminated for any reason, including
1658 discontinuance of the group policy in its entirety or with
1659 respect to an insured class, and who has been continuously
1660 insured under the group policy, and under any group policy
1661 providing similar benefits that the terminated group policy
1662 replaced, for at least 3 months immediately prior to
1663 termination, shall be entitled to have issued to him or her by
1664 the insurer a policy or certificate of health insurance,
1665 referred to in this section as a "converted policy." A group
1666 insurer may meet the requirements of this section by contracting
1667 with another insurer, authorized in this state, to issue an
1668 individual converted policy, which policy has been approved by
1669 the office under s. 627.410. An employee or member shall not be
1670 entitled to a converted policy if termination of his or her
1671 insurance under the group policy occurred because he or she
1672 failed to pay any required contribution, or because any
1673 discontinued group coverage was replaced by similar group
1674 coverage within 31 days after discontinuance.

1675 ~~(9) PREEXISTING CONDITION PROVISION. The converted policy~~

1676 | ~~shall not exclude a preexisting condition not excluded by the~~
 1677 | ~~group policy. However, the converted policy may provide that any~~
 1678 | ~~hospital, surgical, or medical benefits payable under the~~
 1679 | ~~converted policy may be reduced by the amount of any such~~
 1680 | ~~benefits payable under the group policy after the termination of~~
 1681 | ~~coverage under the group policy. The converted policy may also~~
 1682 | ~~provide that during the first policy year the benefits payable~~
 1683 | ~~under the converted policy, together with the benefits payable~~
 1684 | ~~under the group policy, shall not exceed those that would have~~
 1685 | ~~been payable had the individual's insurance under the group~~
 1686 | ~~policy remained in force.~~

1687 | (14)~~(15)~~ BENEFIT LEVELS.—If the benefit levels required in
 1688 | subsection (9) ~~(10)~~ exceed the benefit levels provided under the
 1689 | group policy, the conversion policy may offer benefits which are
 1690 | substantially similar to those provided under the group policy
 1691 | in lieu of those required in subsection (9) ~~(10)~~.

1692 | Section 25. Paragraph (b) of subsection (5) of section
 1693 | 627.6692, Florida Statutes, is amended to read:

1694 | 627.6692 Florida Health Insurance Coverage Continuation
 1695 | Act.—

1696 | (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.—

1697 | (b) Coverage under the group health plan must, at a
 1698 | minimum, extend for the period beginning on the date of the
 1699 | qualifying event and ending not earlier than the earliest of the
 1700 | following:

1701 1. The date that is 18 months after the date on which the
 1702 qualified beneficiary's benefits under the group health plan
 1703 would otherwise have ceased because of a qualifying event.

1704 2. The date on which coverage ceases under the group
 1705 health plan by reason of a failure to make timely payment of the
 1706 applicable premium with respect to any qualified beneficiary.

1707 3. The date a qualified beneficiary becomes covered under
 1708 any other group health plan, ~~if the qualified beneficiary will~~
 1709 ~~not be subject to any exclusion or limitation because of a~~
 1710 ~~preexisting condition of that beneficiary.~~

1711 4. The date a qualified beneficiary is entitled to
 1712 benefits under either part A or part B of Title XVIII of the
 1713 Social Security Act (Medicare).

1714 5. The date on which the employer terminates coverage
 1715 under the group health plan for all employees. If the employer
 1716 terminates coverage under the group health plan for all
 1717 employees and if such group health plan is replaced by similar
 1718 coverage under another group health plan, the qualified
 1719 beneficiary shall have the right to become covered under the new
 1720 group health plan for the balance of the period that she or he
 1721 would have remained covered under the prior group health plan. A
 1722 qualified beneficiary is to be treated in the same manner as an
 1723 active beneficiary for whom a qualifying event has not taken
 1724 place.

1725 Section 26. Subsection (1) of section 627.66997, Florida

1726 Statutes, is amended to read:

1727 627.66997 Stop-loss insurance.—

1728 (1) A self-insured health benefit plan established or
 1729 maintained by a small employer, as defined in s. 627.6699(3) ~~s.~~
 1730 ~~627.6699(3)(v)~~, is exempt from s. 627.6699 and may use a stop-
 1731 loss insurance policy issued to the employer. For purposes of
 1732 this subsection, the term "stop-loss insurance policy" means an
 1733 insurance policy issued to a small employer which covers the
 1734 small employer's obligation for the excess cost of medical care
 1735 on an equivalent basis per employee provided under a self-
 1736 insured health benefit plan.

1737 (a) A small employer stop-loss insurance policy is
 1738 considered a health insurance policy and is subject to s.
 1739 627.6699 if the policy has an aggregate attachment point that is
 1740 lower than the greatest of:

1741 1. Two thousand dollars multiplied by the number of
 1742 employees;

1743 2. One hundred twenty percent of expected claims, as
 1744 determined by the stop-loss insurer in accordance with actuarial
 1745 standards of practice; or

1746 3. Twenty thousand dollars.

1747 (b) Once claims under the small employer health benefit
 1748 plan reach the aggregate attachment point set forth in paragraph
 1749 (a), the stop-loss insurance policy authorized under this
 1750 section must cover 100 percent of all claims that exceed the

1751 aggregate attachment point.

1752 Section 27. Subsection (1), paragraphs (b) and (c) of
1753 subsection (2), and paragraph (c) of subsection (3) of section
1754 627.6741, Florida Statutes, are amended to read:

1755 627.6741 Issuance, cancellation, nonrenewal, and
1756 replacement.—

1757 (1)(a) An insurer issuing Medicare supplement policies in
1758 this state shall offer the opportunity of enrolling in a
1759 Medicare supplement policy, without conditioning the issuance or
1760 effectiveness of the policy on, and without discriminating in
1761 the price of the policy based on, the medical or health status
1762 or preexisting conditions or receipt of health care by the
1763 individual:

1764 1. To any individual who is 65 years of age or older, or
1765 under 65 years of age and eligible for Medicare by reason of
1766 disability or end-stage renal disease, and who resides in this
1767 state, upon the request of the individual during the 6-month
1768 period beginning with the first month in which the individual
1769 has attained 65 years of age and is enrolled in Medicare Part B,
1770 or is eligible for Medicare by reason of a disability or end-
1771 stage renal disease, and is enrolled in Medicare Part B; or

1772 2. To any individual who is 65 years of age or older, or
1773 under 65 years of age and eligible for Medicare by reason of a
1774 disability or end-stage renal disease, who is enrolled in
1775 Medicare Part B, and who resides in this state, upon the request

1776 of the individual during the 2-month period following
1777 termination of coverage under a group health insurance policy.

1778 (b) The 6-month period to enroll in a Medicare supplement
1779 policy for an individual who is under 65 years of age and is
1780 eligible for Medicare by reason of disability or end-stage renal
1781 disease and otherwise eligible under subparagraph (a)1. or
1782 subparagraph (a)2. and first enrolled in Medicare Part B before
1783 October 1, 2009, begins on October 1, 2009.

1784 (c) A company that has offered Medicare supplement
1785 policies to individuals under 65 years of age who are eligible
1786 for Medicare by reason of disability or end-stage renal disease
1787 before October 1, 2009, may, for one time only, effect a rate
1788 schedule change that redefines the age bands of the premium
1789 classes without activating the period of discontinuance required
1790 by s. 627.410(6)(e)2.

1791 (d) As a part of an insurer's rate filings, before and
1792 including the insurer's first rate filing for a block of policy
1793 forms in 2015, notwithstanding the provisions of s.
1794 627.410(6)(e)3., an insurer shall consider the experience of the
1795 policies or certificates for the premium classes including
1796 individuals under 65 years of age and eligible for Medicare by
1797 reason of disability or end-stage renal disease separately from
1798 the balance of the block so as not to affect the other premium
1799 classes. For filings in such time period only, credibility of
1800 that experience shall be as follows: if a block of policy forms

1801 has 1,250 or more policies or certificates in force in the age
1802 band including ages under 65 years of age, full or 100-percent
1803 credibility shall be given to the experience; and if fewer than
1804 250 policies or certificates are in force, no or zero-percent
1805 credibility shall be given. Linear interpolation shall be used
1806 for in-force amounts between the low and high values. Florida-
1807 only experience shall be used if it is 100-percent credible. If
1808 Florida-only experience is not 100-percent credible, a
1809 combination of Florida-only and nationwide experience shall be
1810 used. If Florida-only experience is zero-percent credible,
1811 nationwide experience shall be used. The insurer may file its
1812 initial rates and any rate adjustment based upon the experience
1813 of these policies or certificates or based upon expected claim
1814 experience using experience data of the same company, other
1815 companies in the same or other states, or using data publicly
1816 available from the Centers for Medicaid and Medicare Services if
1817 the insurer's combined Florida and nationwide experience is not
1818 100-percent credible, separate from the balance of all other
1819 Medicare supplement policies.

1820
1821 A Medicare supplement policy issued to an individual under
1822 subparagraph (a)1. or subparagraph (a)2. may not exclude
1823 benefits based on a preexisting condition ~~if the individual has~~
1824 ~~a continuous period of creditable coverage, as defined in s.~~
1825 ~~627.6562(3), of at least 6 months as of the date of application~~

1826 ~~for coverage.~~ As used in this section, the term "preexisting
 1827 condition" has the same meaning as defined in s. 627.6487.

1828 (2) For both individual and group Medicare supplement
 1829 policies:

1830 ~~(b) If it is not replacing an existing policy, a Medicare~~
 1831 ~~supplement policy shall not limit or preclude liability under~~
 1832 ~~the policy for a period longer than 6 months because of a health~~
 1833 ~~condition existing before the policy is effective. The policy~~
 1834 ~~may not define a preexisting condition more restrictively than a~~
 1835 ~~condition for which medical advice was given or treatment was~~
 1836 ~~recommended by or received from a physician within 6 months~~
 1837 ~~before the effective date of coverage.~~

1838 (b)(e) If a Medicare supplement policy or certificate
 1839 replaces another Medicare supplement policy or certificate or
 1840 creditable coverage as defined in s. 627.6562(3), the replacing
 1841 insurer shall waive any time periods applicable to ~~preexisting~~
 1842 ~~conditions~~, waiting periods, elimination periods, and
 1843 probationary periods in the new Medicare supplement policy for
 1844 similar benefits to the extent such time was spent under the
 1845 original policy.

1846 (3) For group Medicare supplement policies:

1847 (c) If a group Medicare supplement policy is replaced by
 1848 another group Medicare supplement policy purchased by the same
 1849 policyholder, the succeeding insurer shall offer coverage to all
 1850 persons covered under the old group policy on its date of

1851 termination. Coverage under the new group policy may not result
 1852 in any exclusion for preexisting conditions ~~that would have been~~
 1853 ~~covered under the group policy being replaced.~~

1854 Section 28. Paragraph (d) of subsection (3) of section
 1855 631.818, Florida Statutes, is amended to read:

1856 631.818 Powers and duties of the plan.—

1857 (3) The plan may appoint one or more HMOs in the same
 1858 geographical area as defined in s. 641.19 to provide health care
 1859 services, subject to all of the following conditions:

1860 (d) Such coverage may ~~shall~~ not exclude a preexisting
 1861 condition ~~not excluded by the policy of the insolvent HMO.~~

1862 Section 29. Paragraphs (f), (g), and (h) of subsection (1)
 1863 of section 641.185, Florida Statutes, are amended to read:

1864 641.185 Health maintenance organization subscriber
 1865 protections.—

1866 (1) With respect to the provisions of this part and part
 1867 III, the principles expressed in the following statements serve
 1868 as standards to be followed by the commission, the office, the
 1869 department, and the Agency for Health Care Administration in
 1870 exercising their powers and duties, in exercising administrative
 1871 discretion, in administrative interpretations of the law, in
 1872 enforcing its provisions, and in adopting rules:

1873 (f) A health maintenance organization subscriber should
 1874 receive the flexibility to transfer to another Florida health
 1875 maintenance organization, regardless of health status or

HB 1293

2020

1876 preexisting conditions, pursuant to ss. 641.228, 641.3104,
1877 641.3107, 641.3111, 641.3921, and 641.3922. As used in this
1878 section, the term "preexisting condition" has the same meaning
1879 as defined in s. 641.31077.

1880 (g) A health maintenance organization subscriber should be
1881 eligible for coverage without discrimination against individual
1882 participants and beneficiaries of group plans based on health
1883 status pursuant to s. 641.31073 or based on preexisting
1884 conditions pursuant to s. 641.31077.

1885 (h) A health maintenance organization that issues a group
1886 health contract must: ~~provide coverage for preexisting~~
1887 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
1888 coverage pursuant to s. 641.31074; provide notice of
1889 cancellation pursuant to s. 641.3108; provide extension of
1890 benefits pursuant to s. 641.3111; provide for conversion on
1891 termination of eligibility pursuant to s. 641.3921; and provide
1892 for conversion contracts and conditions pursuant to s. 641.3922.

1893 Section 30. Paragraph (b) of subsection (5) of section
1894 641.3007, Florida Statutes, is amended to read:

1895 641.3007 HIV infection and AIDS for contract purposes.—

1896 (5) RESTRICTIONS ON CONTRACT EXCLUSIONS AND LIMITATIONS.—

1897 (b) No health maintenance organization contract shall
1898 exclude or limit coverage for exposure to the HIV infection or a
1899 specific sickness or medical condition derived from such
1900 infection, ~~except as provided in a preexisting condition clause.~~

1901 Section 31. Paragraph (c) of subsection (3) and
 1902 subsections (16) and (47) of section 641.31, Florida Statutes,
 1903 are amended to read:

1904 641.31 Health maintenance contracts.—

1905 (3)

1906 (c) The office shall disapprove any form filed under this
 1907 subsection, or withdraw any previous approval thereof, if the
 1908 form:

1909 1. Is in any respect in violation of, or does not comply
 1910 with, any provision of this part or rule adopted thereunder.

1911 2. Contains or incorporates by reference, where such
 1912 incorporation is otherwise permissible, any inconsistent,
 1913 ambiguous, or misleading clauses or exceptions and conditions
 1914 which deceptively affect the risk purported to be assumed in the
 1915 general coverage of the contract.

1916 3. Has any title, heading, or other indication of its
 1917 provisions which is misleading.

1918 4. Is printed or otherwise reproduced in such a manner as
 1919 to render any material provision of the form substantially
 1920 illegible.

1921 5. Contains provisions which are unfair, inequitable, or
 1922 contrary to the public policy of this state or which encourage
 1923 misrepresentation.

1924 6. Excludes coverage for human immunodeficiency virus
 1925 infection or acquired immune deficiency syndrome or contains

1926 limitations in the benefits payable, or in the terms or
1927 conditions of such contract, for human immunodeficiency virus
1928 infection or acquired immune deficiency syndrome which are
1929 different from ~~than~~ those that ~~which~~ apply to any other sickness
1930 or medical condition.

1931 7. Excludes coverage for a preexisting condition or
1932 contains limitations in the benefits payable for a preexisting
1933 condition. As used in this section, the term "preexisting
1934 condition" has the same meaning as defined in s. 641.31077.

1935 (16) The contracts must clearly disclose the intent of the
1936 health maintenance organization as to the applicability ~~or~~
1937 ~~nonapplicability~~ of coverage to preexisting conditions, as
1938 defined in s. 641.31077. ~~If coverage of the contract is not to~~
1939 ~~be applicable to preexisting conditions, the contract shall~~
1940 ~~specify, in substance, that coverage pertains solely to~~
1941 ~~accidental bodily injuries resulting from accidents occurring~~
1942 ~~after the effective date of coverage and that sicknesses are~~
1943 ~~limited to those which first manifest themselves subsequent to~~
1944 ~~the effective date of coverage.~~

1945 (47) ~~(a) As used in this subsection, the terms "operative~~
1946 ~~date" and "preexisting medical condition" have the same meanings~~
1947 ~~as provided in s. 627.6046.~~

1948 ~~(b) A~~ Not ~~later than 30 days after the operative date, and~~
1949 ~~notwithstanding s. 641.31071 or any other law to the contrary,~~
1950 ~~every health maintenance organization issuing, delivering, or~~

1951 issuing for delivery ~~comprehensive major medical~~ individual or
1952 group health maintenance contracts in this state ~~shall make at~~
1953 ~~least one comprehensive major medical health maintenance~~
1954 ~~contract available to residents in the health maintenance~~
1955 ~~organization's approved service areas of this state, and such~~
1956 ~~health maintenance organization~~ may not exclude, limit, deny, or
1957 delay coverage under such contract due to one or more
1958 preexisting ~~medical~~ conditions, as defined in s. 627.31077. A
1959 health maintenance organization may not limit or exclude
1960 benefits under such contract, including a denial of coverage,
1961 applicable to an individual as a result of information relating
1962 to an individual's health status before the individual's
1963 effective date of coverage, or if coverage is denied, the date
1964 of the denial.

1965 ~~(c) The comprehensive major medical health maintenance~~
1966 ~~contract the health maintenance organization is required to~~
1967 ~~offer under this section must be a contract that had been~~
1968 ~~actively marketed in this state by the health maintenance~~
1969 ~~organization as of the operative date and that was also actively~~
1970 ~~marketed in this state during the year immediately preceding the~~
1971 ~~operative date.~~

1972 Section 32. Subsection (2) of section 641.3102, Florida
1973 Statutes, is amended to read:

1974 641.3102 Restrictions upon expulsion or refusal to issue
1975 or renew contract.—

1976 (2) A health maintenance organization may ~~shall~~ not expel
 1977 or refuse to renew the coverage of, or refuse to enroll, any
 1978 individual member of a subscriber group on the basis of the
 1979 race, color, creed, marital status, sex, or national origin of
 1980 the subscriber or individual. A health maintenance organization
 1981 may ~~shall~~ not expel or refuse to renew the coverage of any
 1982 individual member of a subscriber group on the basis of the age,
 1983 health status, health care needs, preexisting condition as
 1984 defined in s. 641.31077, or prospective costs of health care
 1985 services of the subscriber or individual. ~~Nothing in This~~
 1986 section does not ~~shall~~ prohibit a health maintenance
 1987 organization from requiring that, as a condition of continued
 1988 eligibility for membership, dependents of a subscriber, upon
 1989 reaching a specified age, convert to a converted contract or
 1990 that individuals entitled to have payments for health costs made
 1991 under Title XVIII of the United States Social Security Act, as
 1992 amended, be issued a health maintenance contract for Medicare
 1993 beneficiaries so long as the health maintenance organization is
 1994 authorized to issue health maintenance contracts for Medicare
 1995 beneficiaries.

1996 Section 33. Section 641.31073, Florida Statutes, is
 1997 amended to read:

1998 641.31073 Prohibiting discrimination against individual
 1999 participants and beneficiaries based on health status or
 2000 preexisting conditions.-

HB 1293

2020

2001 (1) Subject to subsection (2), a health maintenance
2002 organization that offers group health insurance coverage may not
2003 establish rules for eligibility, including continued
2004 eligibility, of an individual to enroll under the terms of the
2005 contract based on any of the following health-status-related or
2006 preexisting-condition-related factors in relation to the
2007 individual or a dependent of the individual:

2008 (a) Health status.

2009 (b) Medical condition, including physical and mental
2010 illnesses.

2011 (c) Claims experience.

2012 (d) Receipt of health care.

2013 (e) Medical history.

2014 (f) Genetic information.

2015 (g) Evidence of insurability, including conditions arising
2016 out of acts of domestic violence.

2017 (h) Disability.

2018 (i) Preexisting condition.

2019
2020 As used in this section, the term "preexisting condition" has
2021 the same meaning as defined in s. 641.31077.

2022 (2) Subsection (1) does not:

2023 (a) Require a health maintenance organization to provide
2024 particular benefits other than those provided under the terms of
2025 such plan or coverage.

2026 (b) Prevent such a plan or coverage from establishing
 2027 limitations or restrictions on the amount, level, extent, or
 2028 nature of the benefits or coverage for similarly situated
 2029 individuals enrolled in the plan or coverage.

2030 (3) For purposes of subsection (1), rules for eligibility
 2031 to enroll under a contract include rules for defining any
 2032 applicable affiliation or waiting periods of enrollment.

2033 (4) (a) A health maintenance organization that offers
 2034 health insurance coverage may not require any individual, as a
 2035 condition of enrollment or continued enrollment under the
 2036 contract, to pay a premium or contribution that is greater than
 2037 such premium or contribution for a similarly situated individual
 2038 enrolled under the contract on the basis of any health-status-
 2039 related or preexisting-condition-related factor in relation to
 2040 the individual or to an individual enrolled under the contract
 2041 as a dependent of the individual.

2042 (b) This subsection does not:

2043 1. Restrict the amount that an employer may be charged for
 2044 coverage under a group health insurance contract.

2045 2. Prevent a health maintenance organization offering
 2046 group health insurance coverage from establishing premium
 2047 discounts or rebates or modifying otherwise applicable
 2048 copayments or deductibles in return for adherence to programs of
 2049 health promotion and disease prevention.

2050 Section 34. Paragraph (f) of subsection (2) and paragraph

2051 (a) of subsection (3) of section 641.31074, Florida Statutes,
 2052 are amended to read:

2053 641.31074 Guaranteed renewability of coverage.—

2054 (2) A health maintenance organization may nonrenew or
 2055 discontinue a contract based only on one or more of the
 2056 following conditions:

2057 (f) In the case of coverage that is made available only
 2058 through one or more bona fide associations as defined in s.
 2059 627.6571(5), the membership of an employer in the association,
 2060 on the basis of which the coverage is provided, ceases, but only
 2061 if such coverage is terminated under this paragraph uniformly
 2062 without regard to any health-status-related or preexisting-
 2063 condition-related factor that relates to any covered
 2064 individuals. As used in this section, the term "preexisting
 2065 condition" has the same meaning as defined in s. 641.31077.

2066 (3)(a) A health maintenance organization may discontinue
 2067 offering a particular contract form only if:

2068 1. The health maintenance organization provides notice to
 2069 each contract holder provided coverage of this form in such
 2070 market, and participants and beneficiaries covered under such
 2071 coverage, of such discontinuation at least 90 days before ~~prior~~
 2072 ~~to~~ the date of the nonrenewal of such coverage;

2073 2. The health maintenance organization offers to each
 2074 contract holder provided coverage of this form in such market
 2075 the option to purchase all, or in the case of the large group

HB 1293

2020

2076 market, any other health insurance coverage currently being
2077 offered by the health maintenance organization in such market;
2078 and

2079 3. In exercising the option to discontinue coverage of
2080 this form and in offering the option of coverage under
2081 subparagraph 2., the health maintenance organization acts
2082 uniformly without regard to the claims experience of those
2083 contract holders or any health-status-related or preexisting-
2084 condition-related factor that relates to any participants or
2085 beneficiaries covered or new participants or beneficiaries who
2086 may become eligible for such coverage.

2087 Section 35. Paragraph (a) of subsection (12) of section
2088 641.3903, Florida Statutes, is amended to read:

2089 641.3903 Unfair methods of competition and unfair or
2090 deceptive acts or practices defined.—The following are defined
2091 as unfair methods of competition and unfair or deceptive acts or
2092 practices:

2093 (12) PROHIBITED DISCRIMINATORY PRACTICES.—A health
2094 maintenance organization may not:

2095 (a) Engage or attempt to engage in discriminatory
2096 practices that discourage participation on the basis of actual
2097 or perceived health status or actual or perceived preexisting
2098 condition, as defined in s. 641.31077, of Medicaid recipients.

2099 Section 36. Subsections (10) through (14) of section
2100 641.3922, Florida Statutes, are renumbered as subsections (9)

2101 through (13), respectively, and paragraphs (f) and (g) of
 2102 subsections (7) and present subsection (9) of that section are
 2103 amended, to read:

2104 641.3922 Conversion contracts; conditions.—Issuance of a
 2105 converted contract shall be subject to the following conditions:

2106 (7) REASONS FOR CANCELLATION; TERMINATION.—The converted
 2107 health maintenance contract must contain a cancellation or
 2108 nonrenewability clause providing that the health maintenance
 2109 organization may refuse to renew the contract of any person
 2110 covered thereunder, but cancellation or nonrenewal must be
 2111 limited to one or more of the following reasons:

2112 (f) A dependent of the subscriber has reached the limiting
 2113 age under the converted contract, subject to subsection (11)
 2114 ~~(12)~~; but the refusal to renew coverage shall apply only to
 2115 coverage of the dependent, except in the case of handicapped
 2116 children.

2117 (g) A change in marital status that makes a person
 2118 ineligible under the original terms of the converted contract,
 2119 subject to subsection (11) ~~(12)~~.

2120 ~~(9) PREEXISTING CONDITION PROVISION.—The converted health~~
 2121 ~~maintenance contract shall not exclude a preexisting condition~~
 2122 ~~not excluded by the group contract. However, the converted~~
 2123 ~~health maintenance contract may provide that any coverage~~
 2124 ~~benefits thereunder may be reduced by the amount of any coverage~~
 2125 ~~or benefits under the group health maintenance contract after~~

2126 ~~the termination of the person's coverage or benefits thereunder.~~
2127 ~~The converted health maintenance contract may also include~~
2128 ~~provisions so that during the first coverage year the coverage~~
2129 ~~or benefits under the converted contract, together with the~~
2130 ~~coverage or benefits under the group health maintenance~~
2131 ~~contract, shall not exceed those that would have been provided~~
2132 ~~had the individual's coverage or benefits under the group~~
2133 ~~contract remained in force and effect.~~

2134 Section 37. Section 627.6045, Florida Statutes, is
2135 repealed.

2136 Section 38. Section 627.6046, Florida Statutes, is
2137 repealed.

2138 Section 39. Section 627.6561, Florida Statutes, is
2139 repealed.

2140 Section 40. Section 627.65612, Florida Statutes, is
2141 repealed.

2142 Section 41. Section 641.31071, Florida Statutes, is
2143 repealed.

2144 Section 42. This act shall take effect January 1, 2021.