

By Senator Cruz

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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

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30 disclosures of conflicts of interest; prohibiting
31 acceptance of gifts, bequests, and donations;
32 providing for reimbursement for per diem and travel
33 expenses; requiring the commission to annually report
34 specified information relating to prescription drug
35 prices to the Governor and the Legislature; requiring
36 the report to be posted on specified websites;
37 providing rulemaking authority; amending s. 627.6487,
38 F.S.; revising provisions relating to individual
39 health 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

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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 with respect
73 to the Employee Health Care Access Act; revising the
74 definition of the term "modified community rating";
75 defining the term "preexisting condition"; deleting
76 provisions relating to preexisting condition
77 exclusions and limits; revising the geographic rating
78 factors used by small employer carriers; prohibiting
79 small employer carriers from varying premium rates
80 based on preexisting conditions; revising the rating
81 factors that small employer carriers must use to
82 determine and vary premiums; providing requirements
83 for the premium rates; revising the circumstances
84 under which small employer carriers may modify premium
85 rates within a specified period; prohibiting certain
86 premium credits from being based on preexisting
87 conditions; revising prohibited activities by small

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88 employer carriers; deleting obsolete language;
89 deleting specified information that small employer
90 carriers must disclose under certain circumstances;
91 creating s. 641.1855, F.S.; providing definitions;
92 prohibiting certain health maintenance organizations
93 from establishing, in individual and small employer
94 health maintenance contracts, differentials in premium
95 rates based on preexisting conditions; requiring
96 premium rates for such contracts to be based on
97 certain factors; prohibiting rate modifications within
98 a specified timeframe; providing exceptions; providing
99 applicability; creating s. 641.31077, F.S.; providing
100 legislative intent; providing definitions; prohibiting
101 certain health maintenance organizations from
102 declining to offer coverage to specified groups,
103 employers, and individuals and from imposing
104 preexisting condition exclusions under a contract;
105 providing applicability; amending ss. 408.9091,
106 409.814, 627.429, 627.607, 627.6415, 627.642,
107 627.6425, 627.6426, 627.6512, 627.6525, 627.65625,
108 627.6571, 627.6578, 627.6675, 627.6692, 627.6741,
109 631.818, 641.185, 641.3007, 641.31, 641.3102,
110 641.31073, 641.31074, 641.3903, and 641.3922, F.S.;
111 conforming provisions to changes made by the act;
112 amending ss. 409.816, 627.6475, and 627.66997, F.S.;
113 conforming cross-references; repealing ss. 627.6045,
114 627.6046, 627.6561, 627.65612, and 641.31071, F.S.,
115 relating to preexisting conditions and limits on
116 preexisting conditions; providing an effective date.

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

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

381.02033 Prescription Drug Affordability Commission.—There is established the Prescription Drug Affordability Commission, a commission as defined in s. 20.03. The commission shall review manufacturers' prices, price increases, and introductory prices of prescription drugs and shall determine the reasonableness of these prices, price increases, and introductory prices to ensure prescription drug affordability for the state health care system. The commission shall comply with the requirements of s. 20.052, except as otherwise provided in this section, and shall be administratively housed within the Agency for Health Care Administration.

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

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

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

(c) "Conflict of interest" means:

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

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

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

149 b. A financial benefit that, in the aggregate, exceeds
150 \$5,000 per year and that derives from a company or another
151 individual who owns or manufactures prescription drugs,
152 services, or items to be studied by the commission. As used in
153 this sub-subparagraph, the term "financial benefit" includes,
154 but is not limited to, an honorarium, a fee, a stock, or an
155 increase in the value of an individual's existing stockholdings.

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

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

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

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

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

166 (f) "Trade secret" has the same meaning as defined in s.
167 688.002.

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

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

173 1. Two members appointed by the President of the Senate.
174 The President of the Senate shall also appoint one alternate

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175 commission member, who shall participate in deliberations of the
176 commission if a member appointed by the President of the Senate
177 recuses himself or herself under subsection (12).

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

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

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

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

195 1. The initial member appointed by the Governor shall serve
196 4 years.

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

200 3. Of the initial two members appointed by the Speaker of
201 the House of Representatives, one shall serve 3 years, and one
202 shall serve 2 years.

203 (c) The Governor shall designate the chair, and the chair

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204 shall designate a co-chair from among the other members of the
205 commission.

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

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

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

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

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

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

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

225 1. Comment at a public meeting.

226 2. Submit written comments on a pending decision.

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

231 1. Reviewing a prescription drug cost analysis.

232 2. Voting on whether to impose a cost or payment limit on

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233 payors for a prescription drug.

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

236 (4) REQUIRED MANUFACTURER NOTICES.—

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

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

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

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

250 3.a. Increase the wholesale acquisition cost of a generic
251 or off-patent, sole-source brand name prescription drug by more
252 than 25 percent, or by more than \$300 per course of treatment,
253 during any 12-month period; or

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

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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.

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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 or
307 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-supported,
319 drug-specific patient access programs.

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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 on
333 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 that
346 the commission determines to be relevant to the circumstances
347 for the prescription drug under review.

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

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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 at
362 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.

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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 a
390 prescription drug price notice submitted by a prescription drug
391 manufacturer to the commission or relating to a prescription
392 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 training.
- 404 3. Patients' perspectives.
- 405 4. Health care cost trends and drivers.
- 406 5. Clinical and health services research.

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- 407 6. The state health care marketplace in general.
- 408 (b) Members of the advisory council shall be appointed as
- 409 follows:
- 410 1. Six members appointed by the Secretary of Health Care
- 411 Administration, each member representing a different group as
- 412 follows:
- 413 a. Physicians.
- 414 b. Nurses.
- 415 c. Hospitals.
- 416 d. Health insurers.
- 417 e. A statewide health care advocacy coalition.
- 418 f. A statewide senior advocacy coalition.
- 419 2. Five members appointed by the Governor, each member
- 420 representing a different group as follows:
- 421 a. Pharmaceutical manufacturers.
- 422 b. Pharmaceutical employers.
- 423 c. Pharmacists.
- 424 d. Prescription drug research specialists.
- 425 e. The public.
- 426 (c) Members of the advisory council shall serve 4-year
- 427 terms, except that the initial terms shall be staggered as
- 428 follows:
- 429 1. Of the initial six members appointed by the Secretary of
- 430 Health Care Administration, two shall serve for 4 years, two
- 431 shall serve for 3 years, and two shall serve for 2 years.
- 432 2. Of the initial five members appointed by the Governor,
- 433 two shall serve for 4 years, two shall serve for 3 years, and
- 434 one shall serve for 1 year.
- 435 (d) The Governor shall designate the chair, and the chair

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

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

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

446 (a)1. If a commission or advisory council member, or an
447 immediate family member thereof, has a conflict of interest as
448 defined in subparagraph (1)(c)1. or subparagraph (1)(c)2. that
449 is related to a prescription drug under review, the commission
450 or advisory council member, as applicable, shall recuse himself
451 or herself from any board activity involving such prescription
452 drug, including the review of the prescription drug.

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

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

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

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

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465 c. The commission when:

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

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

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

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

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

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

489 (14) ANNUAL REPORTS.—Beginning January 1, 2021, and
490 annually thereafter, the commission shall report to the
491 Governor, the President of the Senate, and the Speaker of the
492 House of Representatives on general prescription drug price
493 trends, the number of prescription drug manufacturers required

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494 to provide notice under this section, and the number of
495 prescription drugs that were subject to commission review and
496 analysis, including the results of such analysis, as well as the
497 number and disposition of appeals and judicial reviews. The
498 commission shall post the report on its website and the agency's
499 website in a manner that is readily accessible to the public.

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

502 Section 2. Section 627.6487, Florida Statutes, is reordered
503 and amended to read:

504 627.6487 Guaranteed availability of individual health
505 insurance coverage to eligible individuals.—

506 (2)~~(1)~~ Subject to the requirements of this section, each
507 health insurance issuer that offers individual health insurance
508 coverage in this state may not, with respect to an eligible
509 individual who desires to enroll in individual health insurance
510 coverage:

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

513 (b) Impose any preexisting condition exclusion with respect
514 to such coverage; or

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

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523 (1)~~(2)~~ As used in ~~For the purposes of~~ this section, the
524 term:

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

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

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

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

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

544 (II)b. Whose most recent prior creditable coverage was
545 under an individual plan issued in this state by a health
546 insurer or health maintenance organization, which coverage is
547 terminated due to the insurer or health maintenance organization
548 becoming insolvent or discontinuing the offering of all
549 individual coverage in the State of Florida, or due to the
550 insured no longer living in the service area in the State of
551 Florida of the insurer or health maintenance organization that

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552 provides coverage through a network plan in the State of
553 Florida;

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

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

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

562 c.3.~~3.~~ Part A or part B of Title XVIII of the Social Security
563 Act; or

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

567 3.~~(e)~~ With respect to whom the most recent coverage within
568 the coverage period described in subparagraph 1. ~~paragraph (a)~~
569 was not terminated based on a factor described in s.
570 627.6571(2) (a) or (b), relating to nonpayment of premiums or
571 fraud, unless such nonpayment of premiums or fraud was due to
572 acts of an employer or person other than the individual;

573 4.~~(d)~~ Who, having been offered the option of continuation
574 coverage under a COBRA continuation provision or under s.
575 627.6692, elected such coverage; and

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

579 (d) "Preexisting condition" means a condition that was
580 present before the effective date of coverage under a health

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581 insurance policy or the date of the coverage denial, regardless
582 of whether any medical advice, diagnosis, care, or treatment was
583 recommended or received for such condition before that date.

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

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

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

592
593 ~~For purposes of this subsection, policy forms that have~~
594 ~~different cost sharing arrangements or different riders are~~
595 ~~considered to be different policy forms.~~

596 ~~(b) The requirement of this subsection is met for health~~
597 ~~insurance coverage policy forms offered by an issuer in the~~
598 ~~individual market if the issuer offers the policy forms for~~
599 ~~individual health insurance coverage with the largest, and next~~
600 ~~to largest, premium volume of all such policy forms offered by~~
601 ~~the issuer in this state or applicable marketing or service~~
602 ~~area, as prescribed in rules adopted by the commission, in the~~
603 ~~individual market in the period involved. To the greatest extent~~
604 ~~possible, such rules must be consistent with regulations adopted~~
605 ~~by the United States Department of Health and Human Services.~~

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

609 1. Limit the individuals who may be enrolled under such

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610 coverage to those who live, reside, or work within the service
611 area for such network plan; and

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

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

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

623 (b) An issuer, upon denying individual health insurance
624 coverage in any service area in accordance with subparagraph
625 (a)2., may not offer coverage in the individual market within
626 such service area for ~~a period of~~ 180 days after such coverage
627 is denied.

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

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

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

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

646 (5) (a) ~~(7) (a)~~ Subsection (2) ~~(1)~~ does not require that a
647 health insurance issuer that offers health insurance coverage
648 only in connection with group health plans or through one or
649 more bona fide associations, as defined in s. 627.6571(5), or
650 both, offer such health insurance coverage in the individual
651 market.

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

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

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

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

664 2. Shall develop and vary premium rates based only on the
665 factors specified in s. 627.64875. ~~or~~

666 (b) This section does not prevent a health insurance issuer
667 that offers individual health insurance coverage from

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668 establishing premium discounts or rebates or modifying otherwise
669 applicable copayments or deductibles in return for adherence to
670 programs of health promotion and disease prevention.

671 ~~(7)-(9)~~ Each health insurance issuer that offers individual
672 health insurance coverage to an eligible individual shall elect
673 to become a risk-assuming carrier or a reinsuring carrier, as
674 provided by s. 627.6475.

675 ~~(8)-(10)~~ This section applies to individual health insurance
676 coverage offered on or after January 1, 2021 ~~1998~~. ~~An individual~~
677 ~~who would have been eligible for coverage on July 1, 1997, shall~~
678 ~~be eligible for coverage on January 1, 1998, and shall remain~~
679 ~~eligible for the same period of time after January 1, 1998, that~~
680 ~~the individual would have remained eligible for coverage after~~
681 ~~July 1, 1997.~~

682 Section 3. Section 627.64875, Florida Statutes, is created
683 to read:

684 627.64875 Preexisting conditions; premium rates.-

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

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

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

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

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

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697 benefits specified in s. 627.6513(1)-(14).

698 (d) "Preexisting condition" has the same meaning as defined
699 in s. 627.6487.

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

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

706 (a) Decline to offer such coverage to, or deny enrollment
707 of, such individual;

708 (b) Impose any preexisting condition exclusion with respect
709 to such coverage; or

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

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

716 (a) Whether the policy coverage is individual or family
717 coverage.

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

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

724 (d) Tobacco use, except that the health insurance issuer
725 may not charge a tobacco user more than 1 1/15 times the rate

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726 the issuer charges a non-tobacco user for the same coverage.

727

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

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

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

739 (b) In tobacco use;

740 (c) In family composition if the coverage is family
741 coverage;

742 (d) In the coverage benefits requested by the eligible
743 individual; or

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

746 (6) This section applies to any health insurance, as
747 defined in s. 624.603, including short-term health insurance,
748 that is offered under an individual health insurance policy.
749 This section does not apply to disability income insurance or
750 income replacement insurance coverage.

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

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755 Section 4. Section 627.65613, Florida Statutes, is created
756 to read:

757 627.65613 Preexisting conditions.-

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

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

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

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

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

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

772 (b) Impose any preexisting condition exclusion with respect
773 to such coverage.

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

779 (5) The commission may adopt rules to administer this
780 section.

781 Section 5. Section 627.65614, Florida Statutes, is created
782 to read:

783 627.65614 Premium rates for franchise health insurance

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784 policies.-

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

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

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

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

796 (a) Whether the policy coverage is individual or family
797 coverage.

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

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

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

806
807 With respect to family coverage under the franchise health
808 insurance policy, an insurer shall apply the rating variations
809 authorized under this subsection based on the premium
810 attributable to each family member in accordance with commission
811 rules.

812 (3) An insurer authorized to issue, deliver, issue for

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813 delivery, or renew a franchise health insurance policy in this
814 state may not modify the premium rates for coverages under the
815 policy within 12 months after the initial issue date or renewal
816 date, unless there is a change:

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

819 (b) In tobacco use;

820 (c) In family composition if the coverage is family
821 coverage;

822 (d) In the coverage benefits requested by the policyholder
823 or by the group; or

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

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

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

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

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842 of that section are amended, to read:

843 627.6699 Employee Health Care Access Act.—

844 (2) PURPOSE AND INTENT.—The purpose and intent of this
845 section is to promote the availability of health insurance
846 coverage to small employers regardless of their claims
847 experience or their employees' health status or preexisting
848 conditions, to establish rules regarding renewability of that
849 coverage, ~~to establish limitations on the use of exclusions for~~
850 ~~preexisting conditions~~, to provide for establishment of a
851 reinsurance program for coverage of small employers, and to
852 improve the overall fairness and efficiency of the small group
853 health insurance market.

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

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

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

866 (5) AVAILABILITY OF COVERAGE.—

867 (b) Every small employer carrier must, as a condition of
868 transacting business in this state, offer and issue all small
869 employer health benefit plans on a guaranteed-issue basis to
870 every eligible small employer, ~~with 2 to 50 eligible employees,~~

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871 that elects to be covered under such plan, agrees to make the
872 required premium payments, and satisfies the other provisions of
873 the plan. A rider for additional or increased benefits may be
874 medically underwritten and may only be added to the standard
875 health benefit plan. The increased rate charged for the
876 additional or increased benefit must be rated in accordance with
877 this section.

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

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

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

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

896 ~~a. Conditions that, during the 24-month period immediately~~
897 ~~preceding the effective date of coverage, had manifested~~
898 ~~themselves in such a manner as would cause an ordinarily prudent~~
899 ~~person to seek medical advice, diagnosis, care, or treatment or~~

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900 ~~for which medical advice, diagnosis, care, or treatment was~~
901 ~~recommended or received; or~~

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

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

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

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

926 3. In applying minimum participation requirements with
927 respect to a small employer, a small employer carrier shall not
928 consider as an eligible employee employees or dependents who

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929 have qualifying existing coverage in an employer-based group
930 insurance plan or an ERISA qualified self-insurance plan in
931 determining whether the applicable percentage of participation
932 is met. However, a small employer carrier may count eligible
933 employees and dependents who have coverage under another health
934 plan that is sponsored by that employer.

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

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

948 6. A small employer carrier may not modify any health
949 benefit plan issued to a small employer with respect to a small
950 employer or any eligible employee or dependent through riders,
951 endorsements, or otherwise to restrict or exclude coverage for
952 certain diseases or medical conditions otherwise covered by the
953 health benefit plan.

954 7. An initial enrollment period of at least 30 days must be
955 provided. An annual 30-day open enrollment period must be
956 offered to each small employer's eligible employees and their
957 dependents. A small employer carrier must provide special

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958 enrollment periods as required by s. 627.65615.

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

965 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

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987 paragraph. A small employer carrier:

988 a. May not charge an adult in the oldest age band more than
989 3 times the rate the small employer carrier charges an adult in
990 the youngest age band under the same health benefit plan.

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

994 c. Must, with respect to family coverage, apply the rating
995 variations authorized under this subparagraph based on the
996 premium attributable to each family member under the health
997 benefit plan in accordance with commission rules ~~is not required~~
998 ~~to use gender as a rating factor for a nongrandfathered health~~
999 ~~plan.~~

1000 2. Rating factors related to age, ~~gender~~, family
1001 composition, tobacco use, or geographic location may be
1002 developed by each carrier to reflect the carrier's experience.
1003 The factors used by carriers are subject to office review and
1004 approval.

1005 3. Except as provided in subparagraph 4., a small employer
1006 carrier ~~carriers~~ may not modify the rate for a small employer or
1007 an eligible employee within ~~for~~ 12 months after ~~from~~ the initial
1008 issue date or renewal date, unless there is a change:

1009 a. In the group's size, composition, or geographic rating
1010 area as established in accordance with federal law; ~~of the group~~

1011 b. In tobacco use;

1012 c. In family composition if the eligible employee's
1013 coverage is family coverage;

1014 d. In the coverage benefits requested by the eligible
1015 employee or the small employer; or

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1016 e. Due to a requirement by federal law or regulation or due
1017 to an express authorization by state law or rule ~~changes or~~
1018 ~~benefits are changed.~~

1019 4. ~~However,~~ A small employer carrier may modify the rate
1020 one time within the 12 months after the initial issue date for a
1021 small employer who enrolls under a previously issued group
1022 policy that has a common anniversary date for all employers
1023 covered under the policy if:

1024 a. The carrier discloses to the employer in a clear and
1025 conspicuous manner the date of the first renewal and the fact
1026 that the premium may increase on or after that date.

1027 b. The insurer demonstrates to the office that efficiencies
1028 in administration are achieved and reflected in the rates
1029 charged to small employers covered under the policy.

1030 5.4. A carrier may issue a group health insurance policy to
1031 a small employer health alliance or other group association with
1032 rates that reflect a premium credit for expense savings
1033 attributable to administrative activities being performed by the
1034 alliance or group association if such expense savings are
1035 specifically documented in the insurer's rate filing and are
1036 approved by the office. Any such credit may not be based on
1037 different morbidity assumptions or on any other factor related
1038 to the health status, preexisting conditions, or claims
1039 experience of any person covered under the policy. This
1040 subparagraph does not exempt an alliance or group association
1041 from licensure for activities that require licensure under the
1042 insurance code. A carrier issuing a group health insurance
1043 policy to a small employer health alliance or other group
1044 association shall allow any properly licensed and appointed

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1045 agent of that carrier to market and sell the small employer
1046 health alliance or other group association policy. Such agent
1047 shall be paid the usual and customary commission paid to any
1048 agent selling the policy.

1049 6.5 Any adjustments in rates for claims experience, health
1050 status, or duration of coverage may not be charged to individual
1051 employees or dependents. For a small employer's policy, such
1052 adjustments may not result in a rate for the small employer
1053 which deviates more than 15 percent from the carrier's approved
1054 rate. Any such adjustment must be applied uniformly to the rates
1055 charged for all employees and dependents of the small employer.
1056 A small employer carrier may make an adjustment to a small
1057 employer's renewal premium, up to 10 percent annually, due to
1058 the claims experience, health status, or duration of coverage of
1059 the employees or dependents of the small employer. If the
1060 aggregate resulting from the application of such adjustment
1061 exceeds the premium that would have been charged by application
1062 of the approved modified community rate by 4 percent for the
1063 current policy term, the carrier shall limit the application of
1064 such adjustments only to minus adjustments. For any subsequent
1065 policy term, if the total aggregate adjusted premium actually
1066 charged does not exceed the premium that would have been charged
1067 by application of the approved modified community rate by 4
1068 percent, the carrier may apply both plus and minus adjustments.
1069 A small employer carrier may provide a credit to a small
1070 employer's premium based on administrative and acquisition
1071 expense differences resulting from the size of the group. Group
1072 size administrative and acquisition expense factors may be
1073 developed by each carrier to reflect the carrier's experience

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1074 and are subject to office review and approval.

1075 ~~7.6.~~ A small employer carrier rating methodology may
1076 include separate rating categories for one dependent child, for
1077 two dependent children, and for three or more dependent children
1078 for family coverage of employees having a spouse and dependent
1079 children or employees having dependent children only. A small
1080 employer carrier may have fewer, but not greater, numbers of
1081 categories for dependent children than those specified in this
1082 subparagraph.

1083 ~~8.7.~~ Small employer carriers may not use a composite rating
1084 methodology to rate a small employer ~~with fewer than 10~~
1085 ~~employees~~. For the purposes of this subparagraph, the term
1086 "composite rating methodology" means a rating methodology that
1087 averages the impact of the rating factors for age and gender in
1088 the premiums charged to all of the employees of a small
1089 employer.

1090 ~~9.8.~~ A carrier may separate the experience of small
1091 employer groups with fewer than 2 eligible employees from the
1092 experience of small employer groups with 2-50 eligible employees
1093 for purposes of determining an alternative modified community
1094 rating.

1095 a. If a carrier separates the experience of small employer
1096 groups, the rate to be charged to small employer groups of fewer
1097 than 2 eligible employees may not exceed 150 percent of the rate
1098 determined for small employer groups of 2-50 eligible employees.
1099 However, the carrier may charge excess losses of the experience
1100 pool consisting of small employer groups with fewer ~~less~~ than 2
1101 eligible employees to the experience pool consisting of small
1102 employer groups with 2-50 eligible employees so that all losses

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1103 are allocated and the 150-percent rate limit on the experience
 1104 pool consisting of small employer groups with fewer ~~less~~ than 2
 1105 eligible employees is maintained.

1106 b. Notwithstanding s. 627.411(1), the rate to be charged to
 1107 a small employer group of fewer than 2 eligible employees~~,~~
 1108 ~~insured as of July 1, 2002,~~ may be up to 125 percent of the rate
 1109 determined for small employer groups of 2-50 eligible employees
 1110 for the first annual renewal and 150 percent for subsequent
 1111 annual renewals.

1112 ~~10.9.~~ A carrier shall separate the experience of
 1113 grandfathered health plans from nongrandfathered health plans
 1114 for determining rates.

1115 (12) STANDARDS TO ENSURE ~~ASSURE~~ FAIR MARKETING.-

1116 (b) A small employer carrier or agent shall not, directly
 1117 or indirectly, engage in the following activities:

1118 1. Encouraging or directing small employers to refrain from
 1119 filing an application for coverage with the small employer
 1120 carrier because of the health status, preexisting condition,
 1121 claims experience, industry, occupation, or geographic location
 1122 of the small employer.

1123 2. Encouraging or directing small employers to seek
 1124 coverage from another carrier because of the health status,
 1125 preexisting condition, claims experience, industry, occupation,
 1126 or geographic location of the small employer.

1127 (d) A small employer carrier shall not, directly or
 1128 indirectly, enter into any contract, agreement, or arrangement
 1129 with an agent that provides for or results in the compensation
 1130 paid to an agent for the sale of a health benefit plan to be
 1131 varied because of the health status, preexisting condition,

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1132 claims experience, industry, occupation, or geographic location
1133 of the small employer except if the compensation arrangement
1134 provides compensation to an agent on the basis of percentage of
1135 premium, provided that the percentage shall not vary because of
1136 the health status, preexisting condition, claims experience,
1137 industry, occupation, or geographic area of the small employer.

1138 (e) A small employer carrier shall not terminate, fail to
1139 renew, or limit its contract or agreement of representation with
1140 an agent for any reason related to the health status,
1141 preexisting condition, claims experience, occupation, or
1142 geographic location of the small employers placed by the agent
1143 with the small employer carrier unless the agent consistently
1144 engages in practices that violate this section or s. 626.9541.

1145 (13) DISCLOSURE OF INFORMATION.—

1146 (b)1. Subject to subparagraph 3., with respect to a small
1147 employer carrier that offers a health benefit plan to a small
1148 employer, information described in this paragraph is information
1149 that concerns:

1150 a. The provisions of such coverage concerning an insurer's
1151 right to change premium rates and the factors that may affect
1152 changes in premium rates;

1153 b. The provisions of such coverage that relate to
1154 renewability of coverage;

1155 ~~e. The provisions of such coverage that relate to any~~
1156 ~~preexisting condition exclusions;~~ and

1157 c.d. The benefits and premiums available under all health
1158 insurance coverage for which the employer is qualified.

1159 2. Information required under this subsection shall be
1160 provided to small employers in a manner determined to be

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1161 understandable by the average small employer, and shall be
1162 sufficient to reasonably inform small employers of their rights
1163 and obligations under the health insurance coverage.

1164 3. An insurer is not required under this subsection to
1165 disclose any information that is proprietary or a trade secret
1166 under state law.

1167 Section 7. Section 641.1855, Florida Statutes, is created
1168 to read:

1169 641.1855 Premium rates for individual and small employer
1170 health maintenance contracts.—

1171 (1) As used in this section, the term:

1172 (a) "Health maintenance contract" means a health
1173 maintenance contract offered in the individual market, a health
1174 maintenance contract that is individually underwritten, or a
1175 health maintenance contract provided to a small employer.

1176 (b) "Preexisting condition" has the same meaning as defined
1177 in s. 641.31077.

1178 (c) "Short-term health insurance" has the same meaning as
1179 defined in s. 641.31077.

1180 (2) A health maintenance organization that offers a health
1181 maintenance contract in this state may not establish, under such
1182 contract, differentials in premium rates that are based on a
1183 preexisting condition. The health maintenance organization shall
1184 develop premium rates under the contract based on, and shall
1185 vary the rates by, only the following factors:

1186 (a) Whether the contract coverage is individual or family
1187 coverage.

1188 (b) The geographic rating area that is established in
1189 accordance with federal law.

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1190 (c) Age, except that the health maintenance organization
1191 may not charge an adult in the oldest age band more than 3 times
1192 the rate the health maintenance organization charges an adult in
1193 the youngest age band for the same coverage.

1194 (d) Tobacco use, except that the health maintenance
1195 organization may not charge a tobacco user more than 1 1/15
1196 times the rate the health maintenance organization charges a
1197 non-tobacco user for the same coverage.

1198
1199 With respect to family coverage under the health maintenance
1200 contract, a health maintenance organization shall apply the
1201 rating variations authorized under this subsection based on the
1202 premium attributable to each family member in accordance with
1203 commission rules.

1204 (3) A health maintenance organization that offers a health
1205 maintenance contract in this state may not modify the premium
1206 rates for coverages under the health maintenance contract within
1207 12 months after the initial issue date or renewal date, unless
1208 there is a change:

1209 (a) In the individual contract holder's geographic rating
1210 area if the contract is an individual health maintenance
1211 contract, or in the small employer's size, composition, or
1212 geographic rating area established in accordance with federal
1213 law if the contract is a small employer health maintenance
1214 contract;

1215 (b) In tobacco use;

1216 (c) In family composition if the coverage is family
1217 coverage;

1218 (d) In the coverage benefits requested by the contract

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1219 holder or by the small employer; or

1220 (e) Due to a requirement by federal law or regulation or
1221 due to an express authorization by state law or rule.

1222 (4) This section applies to any health insurance, as
1223 defined in s. 624.603, including short-term health insurance,
1224 that is offered under a health maintenance contract. This
1225 section does not apply to disability income insurance or income
1226 replacement insurance coverage.

1227 Section 8. Section 641.31077, Florida Statutes, is created
1228 to read:

1229 641.31077 Preexisting conditions.—

1230 (1) This act establishes protections for those with
1231 preexisting conditions who seek to obtain insurance coverage.

1232 (2) As used in this section, the term:

1233 (a) "Preexisting condition" means a condition that existed
1234 before the effective date of health maintenance coverage or the
1235 date of the coverage denial, regardless of whether any medical
1236 advice, diagnosis, care, or treatment was recommended or
1237 received for such condition before that date.

1238 (b) "Short-term health insurance" means a health
1239 maintenance contract with an expiration date specified in the
1240 contract that is less than 12 months after the original
1241 effective date of the contract and, taking into account renewals
1242 or extensions, has a duration not to exceed 36 months in total.

1243 (3) A health maintenance organization issuing or delivering
1244 an individual or group health maintenance contract in this state
1245 may not, with respect to a group, an employer, or an individual
1246 that is eligible to enroll for coverage under such contract and
1247 that applies for coverage under such contract:

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1248 (a) Decline to offer such coverage to, or deny enrollment
 1249 of, such group, employer, or individual; or

1250 (b) Impose any preexisting condition exclusion with respect
 1251 to such coverage.

1252 (4) This section applies to any health insurance, as
 1253 defined in s. 624.603, including short-term health insurance,
 1254 that is offered under an individual or group health maintenance
 1255 contract. This section does not apply to disability income
 1256 insurance or income replacement insurance coverage.

1257 Section 9. Paragraph (a) of subsection (4) of section
 1258 408.9091, Florida Statutes, is amended to read:

1259 408.9091 Cover Florida Health Care Access Program.—

1260 (4) PROGRAM.—The agency and the office shall jointly
 1261 establish and administer the Cover Florida Health Care Access
 1262 Program.

1263 (a) General Cover Florida plan components must require
 1264 that:

1265 1. Plans are offered on a guaranteed-issue basis to
 1266 enrollees, ~~subject to exclusions for preexisting conditions~~
 1267 ~~approved by the office and the agency.~~

1268 2. Plans are portable such that the enrollee remains
 1269 covered regardless of employment status or the cost sharing of
 1270 premiums.

1271 3. Plans provide for cost containment through limits on the
 1272 number of services, caps on benefit payments, and copayments for
 1273 services.

1274 4. A Cover Florida plan entity makes all benefit plan and
 1275 marketing materials available in English and Spanish.

1276 5. In order to provide for consumer choice, Cover Florida

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1277 plan entities develop two alternative benefit option plans
1278 having different cost and benefit levels, including at least one
1279 plan that provides catastrophic coverage.

1280 6. Plans without catastrophic coverage provide coverage
1281 options for services including, but not limited to:

1282 a. Preventive health services, including immunizations,
1283 annual health assessments, well-woman and well-care services,
1284 and preventive screenings such as mammograms, cervical cancer
1285 screenings, and noninvasive colorectal or prostate screenings.

1286 b. Incentives for routine preventive care.

1287 c. Office visits for the diagnosis and treatment of illness
1288 or injury.

1289 d. Office surgery, including anesthesia.

1290 e. Behavioral health services.

1291 f. Durable medical equipment and prosthetics.

1292 g. Diabetic supplies.

1293 7. Plans providing catastrophic coverage, at a minimum,
1294 provide coverage options for all of the services listed under
1295 subparagraph 6.; however, such plans may include, but are not
1296 limited to, coverage options for:

1297 a. Inpatient hospital stays.

1298 b. Hospital emergency care services.

1299 c. Urgent care services.

1300 d. Outpatient facility services, outpatient surgery, and
1301 outpatient diagnostic services.

1302 8. All plans offer prescription drug benefit coverage, use
1303 a prescription drug manager, or offer a discount drug card.

1304 9. Plan enrollment materials provide information in plain
1305 language on policy benefit coverage, benefit limits, cost-

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1306 sharing requirements, and exclusions and a clear representation
1307 of what is not covered in the plan. Such enrollment materials
1308 must include a standard disclosure form adopted by rule by the
1309 Financial Services Commission, to be reviewed and executed by
1310 all consumers purchasing Cover Florida plan coverage.

1311 10. Plans offered through a qualified employer meet the
1312 requirements of s. 125 of the Internal Revenue Code.

1313 Section 10. Subsection (5) of section 409.814, Florida
1314 Statutes, is amended to read:

1315 409.814 Eligibility.—A child who has not reached 19 years
1316 of age whose family income is equal to or below 200 percent of
1317 the federal poverty level is eligible for the Florida Kidcare
1318 program as provided in this section. If an enrolled individual
1319 is determined to be ineligible for coverage, he or she must be
1320 immediately disenrolled from the respective Florida Kidcare
1321 program component.

1322 ~~(5) A child who is otherwise eligible for the Florida
1323 Kidcare program and who has a preexisting condition that
1324 prevents coverage under another insurance plan as described in
1325 paragraph (4) (a) which would have disqualified the child for the
1326 Florida Kidcare program if the child were able to enroll in the
1327 plan is eligible for Florida Kidcare coverage when enrollment is
1328 possible.~~

1329 Section 11. Subsection (3) of section 409.816, Florida
1330 Statutes, is amended to read:

1331 409.816 Limitations on premiums and cost sharing.—The
1332 following limitations on premiums and cost sharing are
1333 established for the program.

1334 (3) Enrollees in families with a family income above 150

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1335 percent of the federal poverty level who are not receiving
1336 coverage under the Medicaid program or who are not eligible
1337 under s. 409.814(5) ~~s. 409.814(6)~~ may be required to pay
1338 enrollment fees, premiums, copayments, deductibles, coinsurance,
1339 or similar charges on a sliding scale related to income, except
1340 that the total annual aggregate cost sharing with respect to all
1341 children in a family may not exceed 5 percent of the family's
1342 income. However, copayments, deductibles, coinsurance, or
1343 similar charges may not be imposed for preventive services,
1344 including well-baby and well-child care, age-appropriate
1345 immunizations, and routine hearing and vision screenings.

1346 Section 12. Paragraph (b) of subsection (5) of section
1347 627.429, Florida Statutes, is amended to read:

1348 627.429 Medical tests for HIV infection and AIDS for
1349 insurance purposes.—

1350 (5) RESTRICTIONS ON COVERAGE EXCLUSIONS AND LIMITATIONS.—

1351 (b) Subject to the total benefits limits in a health
1352 insurance policy, no health insurance policy shall contain an
1353 exclusion or limitation with respect to coverage for exposure to
1354 the HIV infection or a specific sickness or medical condition
1355 derived from such infection, ~~except as provided in a preexisting~~
1356 ~~condition clause~~. This paragraph does not prohibit the issuance
1357 of accident-only or specified disease health policies.

1358 Section 13. Subsection (2) of section 627.607, Florida
1359 Statutes, is amended to read:

1360 627.607 Time limit on certain defenses.—

1361 (2) A policy may, in place of the provision set forth in
1362 subsection (1), include the following provision:

1363 "Incontestable:

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1364 ~~(a) Misstatements in the Application: After this policy has~~
1365 been in force for 2 years during the insured's lifetime
1366 (excluding any period during which the insured is disabled), the
1367 insurer cannot contest the statements in the application.

1368 ~~(b) Preexisting Conditions: No claim for loss incurred or~~
1369 ~~disability starting after 2 years from the issue date will be~~
1370 ~~reduced or denied because a sickness or physical condition, not~~
1371 ~~excluded by name or specific description before the date of~~
1372 ~~loss, had existed before the effective date of coverage."~~

1373 Section 14. Subsection (1) of section 627.6415, Florida
1374 Statutes, is amended to read:

1375 627.6415 Coverage for natural-born, adopted, and foster
1376 children; children in insured's custodial care.—

1377 (1) A health insurance policy that provides coverage for a
1378 member of the family of the insured shall, as to the family
1379 member's coverage, provide that the health insurance benefits
1380 applicable to children of the insured also apply to an adopted
1381 child or a foster child of the insured placed in compliance with
1382 chapter 63, before ~~prior to~~ the child's 18th birthday, from the
1383 moment of placement in the residence of the insured. ~~Except in~~
1384 ~~the case of a foster child,~~ The policy may not exclude coverage
1385 for any preexisting condition of the child. In the case of a
1386 newborn child, coverage begins at the moment of birth if a
1387 written agreement to adopt the child has been entered into by
1388 the insured before ~~prior to~~ the birth of the child, whether or
1389 not the agreement is enforceable. This section does not require
1390 coverage for an adopted child who is not ultimately placed in
1391 the residence of the insured in compliance with chapter 63.

1392 Section 15. Paragraph (c) of subsection (2) of section

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1393 627.642, Florida Statutes, is amended to read:

1394 627.642 Outline of coverage.—

1395 (2) The outline of coverage shall contain:

1396 (c) A summary statement of the principal exclusions and
1397 limitations or reductions contained in the policy, including,
1398 but not limited to, ~~preexisting conditions~~, probationary
1399 periods, elimination periods, deductibles, coinsurance, and any
1400 age limitations or reductions.

1401 Section 16. Paragraphs (d) and (e) of subsection (2) and
1402 paragraph (a) of subsection (3) of section 627.6425, Florida
1403 Statutes, are amended to read:

1404 627.6425 Renewability of individual coverage.—

1405 (2) An insurer may nonrenew or discontinue health insurance
1406 coverage of an individual in the individual market based only on
1407 one or more of the following:

1408 (d) In the case of a health insurer that offers health
1409 insurance coverage in the market through a network plan, the
1410 individual no longer resides, lives, or works in the service
1411 area, or in an area for which the insurer is authorized to do
1412 business, but only if such coverage is terminated under this
1413 paragraph uniformly without regard to any health-status-related
1414 or preexisting-condition-related factor of covered individuals.

1415 As used in this section, the term "preexisting condition" has
1416 the same meaning as defined in s. 627.6487.

1417 (e) In the case of health insurance coverage that is made
1418 available in the individual market only through one or more bona
1419 fide associations, as defined in s. 627.6571(5), the membership
1420 of the individual in the association, on the basis of which the
1421 coverage is provided, ceases, but only if such coverage is

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1422 terminated under this paragraph uniformly without regard to any
1423 health-status-related or preexisting-condition-related factor of
1424 covered individuals.

1425 (3) (a) If an insurer decides to discontinue offering a
1426 particular policy form for health insurance coverage offered in
1427 the individual market, coverage under such form may be
1428 discontinued by the insurer only if:

1429 1. The insurer provides notice to each covered individual
1430 provided coverage under this policy form in the individual
1431 market of such discontinuation at least 90 days before the date
1432 of the nonrenewal of such coverage;

1433 2. The insurer offers to each individual in the individual
1434 market provided coverage under this policy form the option to
1435 purchase any other individual health insurance coverage
1436 currently being offered by the insurer for individuals in such
1437 market in the state; and

1438 3. In exercising the option to discontinue coverage of a
1439 policy form and in offering the option of coverage under
1440 subparagraph 2., the insurer acts uniformly without regard to
1441 any health-status-related or preexisting-condition-related
1442 factor of enrolled individuals or individuals who may become
1443 eligible for such coverage. If a policy form covers both
1444 grandfathered and nongrandfathered health plans, an insurer may
1445 nonrenew coverage only for the nongrandfathered health plans, in
1446 which case the requirements of subparagraphs 1. and 2. apply
1447 only to the nongrandfathered health plans. As used in this
1448 subparagraph, the terms "grandfathered health plan" and
1449 "nongrandfathered health plan" have the same meaning as provided
1450 in s. 627.402.

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1451 Section 17. Subsection (2) of section 627.6426, Florida
1452 Statutes, is amended to read:

1453 627.6426 Short-term health insurance.—

1454 (2) All contracts for short-term health insurance entered
1455 into by an issuer and an individual seeking coverage shall
1456 include the following disclosure:

1457
1458 "This coverage is not required to comply with certain federal
1459 market requirements for health insurance, principally those
1460 contained in the Patient Protection and Affordable Care Act. Be
1461 sure to check your policy carefully to make sure you are aware
1462 of any exclusions or limitations regarding coverage of
1463 ~~preexisting conditions or~~ health benefits (such as
1464 hospitalization, emergency services, maternity care, preventive
1465 care, prescription drugs, and mental health and substance use
1466 disorder services). Your policy might also have lifetime and/or
1467 annual dollar limits on health benefits. If this coverage
1468 expires or you lose eligibility for this coverage, you might
1469 have to wait until an open enrollment period to get other health
1470 insurance coverage."

1471 Section 18. Paragraphs (b) and (e) of subsection (2) of
1472 section 627.6475, Florida Statutes, are amended to read:

1473 627.6475 Individual reinsurance pool.—

1474 (2) DEFINITIONS.—As used in this section:

1475 (b) "Health insurance issuer," "issuer," and "individual
1476 health insurance" have the same meaning as defined in s.
1477 627.6487 ~~ascribed in s. 627.6487(2).~~

1478 (e) "Eligible individual" has the same meaning as defined
1479 in s. 627.6487 ~~ascribed in s. 627.6487(3).~~

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1480 Section 19. Section 627.6512, Florida Statutes, is amended
1481 to read:

1482 627.6512 Exemption of certain group health insurance
1483 policies.—Sections ~~627.6561~~, 627.65615, 627.65625, and 627.6571
1484 do not apply to any group insurance policy in relation to its
1485 provision of benefits described in s. 627.6513(1)-(14).

1486 Section 20. Subsection (2) of section 627.6525, Florida
1487 Statutes, is amended to read:

1488 627.6525 Short-term health insurance.—

1489 (2) All contracts for short-term health insurance entered
1490 into by an issuer and a party seeking coverage shall include the
1491 following disclosure:

1492 "This coverage is not required to comply with certain federal
1493 market requirements for health insurance, principally those
1494 contained in the Patient Protection and Affordable Care Act. Be
1495 sure to check your policy carefully to make sure you are aware
1496 of any exclusions or limitations regarding coverage of
1497 ~~preexisting conditions or~~ health benefits (such as
1498 hospitalization, emergency services, maternity care, preventive
1499 care, prescription drugs, and mental health and substance use
1500 disorder services). Your policy might also have lifetime and/or
1501 annual dollar limits on health benefits. If this coverage
1502 expires or you lose eligibility for this coverage, you might
1503 have to wait until an open enrollment period to get other health
1504 insurance coverage."

1505 Section 21. Section 627.65625, Florida Statutes, is amended
1506 to read:

1507 627.65625 Prohibiting discrimination against individual
1508 participants and beneficiaries based on health status or

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1509 preexisting conditions.-

1510 (1) Subject to subsection (2), an insurer that offers a
 1511 group health insurance policy may not establish rules for
 1512 eligibility, including continued eligibility, of an individual
 1513 to enroll under the terms of the policy based on any of the
 1514 following health-status-related or preexisting-condition-related
 1515 factors in relation to the individual or a dependent of the
 1516 individual:

1517 (a) Health status.

1518 (b) Medical condition, including physical and mental
 1519 illnesses.

1520 (c) Claims experience.

1521 (d) Receipt of health care.

1522 (e) Medical history.

1523 (f) Genetic information.

1524 (g) Evidence of insurability, including conditions arising
 1525 out of acts of domestic violence.

1526 (h) Disability.

1527 (i) Preexisting condition.

1528

1529 As used in this section, the term "preexisting condition" has
 1530 the same meaning as defined in s. 627.6487.

1531 (2) Subsection (1) does not:

1532 (a) Require an insurer to provide particular benefits other
 1533 than those provided under the terms of such plan or coverage.

1534 (b) Prevent such a plan or coverage from establishing
 1535 limitations or restrictions on the amount, level, extent, or
 1536 nature of the benefits or coverage for similarly situated
 1537 individuals enrolled in the plan or coverage.

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1538 (3) For purposes of subsection (1), rules for eligibility
1539 to enroll under a policy include rules for defining any
1540 applicable waiting periods of enrollment.

1541 (4) (a) An insurer that offers health insurance coverage may
1542 not require any individual, as a condition of enrollment or
1543 continued enrollment under the policy, to pay a premium or
1544 contribution that is greater than such premium or contribution
1545 for a similarly situated individual enrolled under the policy on
1546 the basis of any health-status-related or preexisting-condition-
1547 related factor in relation to the individual or to an individual
1548 enrolled under the policy as a dependent of the individual.

1549 (b) This subsection does not:

1550 1. Restrict the amount that an employer may be charged for
1551 coverage under a group health insurance policy; or

1552 2. Prevent an insurer that offers group health insurance
1553 coverage from establishing premium discounts or rebates or
1554 modifying otherwise applicable copayments or deductibles in
1555 return for adherence to programs of health promotion and disease
1556 prevention.

1557 Section 22. Paragraph (f) of subsection (2), paragraph (a)
1558 of subsection (3), and subsection (5) of section 627.6571,
1559 Florida Statutes, are amended to read:

1560 627.6571 Guaranteed renewability of coverage.—

1561 (2) An insurer may nonrenew or discontinue a group health
1562 insurance policy based only on one or more of the following
1563 conditions:

1564 (f) In the case of health insurance coverage that is made
1565 available only through one or more bona fide associations as
1566 defined in subsection (5) or through one or more small employer

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1567 health alliances as described in s. 627.654(1)(b), the
1568 membership of an employer in the association or in the small
1569 employer health alliance, on the basis of which the coverage is
1570 provided, ceases, but only if such coverage is terminated under
1571 this paragraph uniformly without regard to any health-status-
1572 related or preexisting-condition-related factor that relates to
1573 any covered individuals. As used in this section, the term
1574 "preexisting condition" has the same meaning as defined in s.
1575 627.6487.

1576 (3)(a) An insurer may discontinue offering a particular
1577 policy form of group health insurance coverage offered in the
1578 small-group market or large-group market only if:

1579 1. The insurer provides notice to each policyholder
1580 provided coverage under this policy form, and to participants
1581 and beneficiaries covered under such coverage, of such
1582 discontinuation at least 90 days before the date of the
1583 nonrenewal of such coverage;

1584 2. The insurer offers to each policyholder provided
1585 coverage under this policy form the option to purchase all, or
1586 in the case of the large-group market, any other health
1587 insurance coverage currently being offered by the insurer in
1588 such market; and

1589 3. In exercising the option to discontinue coverage of this
1590 form and in offering the option of coverage under subparagraph
1591 2., the insurer acts uniformly without regard to the claims
1592 experience of those policyholders or any health-status-related
1593 or preexisting-condition-related factor that relates to any
1594 participants or beneficiaries covered or new participants or
1595 beneficiaries who may become eligible for such coverage. If a

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1596 policy form covers both grandfathered and nongrandfathered
1597 health plans, an insurer may nonrenew coverage only for
1598 nongrandfathered health plans, in which case the requirements of
1599 subparagraphs 1. and 2. apply only to the nongrandfathered
1600 health plans. As used in this subparagraph, the terms
1601 "grandfathered health plan" and "nongrandfathered health plan"
1602 have the same meanings as provided in s. 627.402.

1603 (5) As used in this section, the term "bona fide
1604 association" means an association that:

1605 (a) Has been actively in existence for at least 5 years;

1606 (b) Has been formed and maintained in good faith for
1607 purposes other than obtaining insurance;

1608 (c) Does not condition membership in the association on any
1609 health-status-related or preexisting-condition-related factor
1610 that relates to an individual, including an employee of an
1611 employer or a dependent of an employee;

1612 (d) Makes health insurance coverage offered through the
1613 association available to all members regardless of any health-
1614 status-related or preexisting-condition-related factor that
1615 relates to such members or individuals eligible for coverage
1616 through a member; and

1617 (e) Does not make health insurance coverage offered through
1618 the association available other than in connection with a member
1619 of the association.

1620 Section 23. Subsection (1) of section 627.6578, Florida
1621 Statutes, is amended to read:

1622 627.6578 Coverage for natural-born, adopted, and foster
1623 children; children in insured's custodial care.-

1624 (1) A group, blanket, or franchise health insurance policy

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1625 that provides coverage for a family member of the
1626 certificateholder or subscriber shall, as to such family
1627 member's coverage, provide that benefits applicable to children
1628 of the certificateholder or subscriber also apply to an adopted
1629 child or a foster child of the certificateholder or subscriber
1630 placed in compliance with chapter 63, from the moment of
1631 placement in the residence of the certificateholder or
1632 subscriber. ~~Except in the case of a foster child,~~ The policy may
1633 not exclude coverage for any preexisting condition of the child.
1634 In the case of a newborn child, coverage begins at the moment of
1635 birth if a written agreement to adopt such child has been
1636 entered into by the certificateholder or subscriber before ~~prior~~
1637 ~~to~~ the birth of the child, whether or not the agreement is
1638 enforceable. This section does not require coverage for an
1639 adopted child who is not ultimately placed in the residence of
1640 the certificateholder or subscriber in compliance with chapter
1641 63.

1642 Section 24. Present subsections (10) through (20) of
1643 section 627.6675, Florida Statutes, are renumbered as
1644 subsections (9) through (19), respectively, and subsection (9)
1645 and present subsection (15) of that section are amended, to
1646 read:

1647 627.6675 Conversion on termination of eligibility.—Subject
1648 to all of the provisions of this section, a group policy
1649 delivered or issued for delivery in this state by an insurer or
1650 nonprofit health care services plan that provides, on an
1651 expense-incurred basis, hospital, surgical, or major medical
1652 expense insurance, or any combination of these coverages, shall
1653 provide that an employee or member whose insurance under the

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1654 group policy has been terminated for any reason, including
1655 discontinuance of the group policy in its entirety or with
1656 respect to an insured class, and who has been continuously
1657 insured under the group policy, and under any group policy
1658 providing similar benefits that the terminated group policy
1659 replaced, for at least 3 months immediately prior to
1660 termination, shall be entitled to have issued to him or her by
1661 the insurer a policy or certificate of health insurance,
1662 referred to in this section as a "converted policy." A group
1663 insurer may meet the requirements of this section by contracting
1664 with another insurer, authorized in this state, to issue an
1665 individual converted policy, which policy has been approved by
1666 the office under s. 627.410. An employee or member shall not be
1667 entitled to a converted policy if termination of his or her
1668 insurance under the group policy occurred because he or she
1669 failed to pay any required contribution, or because any
1670 discontinued group coverage was replaced by similar group
1671 coverage within 31 days after discontinuance.

1672 ~~(9) PREEXISTING CONDITION PROVISION. The converted policy~~
1673 ~~shall not exclude a preexisting condition not excluded by the~~
1674 ~~group policy. However, the converted policy may provide that any~~
1675 ~~hospital, surgical, or medical benefits payable under the~~
1676 ~~converted policy may be reduced by the amount of any such~~
1677 ~~benefits payable under the group policy after the termination of~~
1678 ~~coverage under the group policy. The converted policy may also~~
1679 ~~provide that during the first policy year the benefits payable~~
1680 ~~under the converted policy, together with the benefits payable~~
1681 ~~under the group policy, shall not exceed those that would have~~
1682 ~~been payable had the individual's insurance under the group~~

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1683 ~~policy remained in force.~~

1684 (14)~~(15)~~ BENEFIT LEVELS.—If the benefit levels required in
1685 subsection (9) ~~(10)~~ exceed the benefit levels provided under the
1686 group policy, the conversion policy may offer benefits which are
1687 substantially similar to those provided under the group policy
1688 in lieu of those required in subsection (9) ~~(10)~~.

1689 Section 25. Paragraph (b) of subsection (5) of section
1690 627.6692, Florida Statutes, is amended to read:

1691 627.6692 Florida Health Insurance Coverage Continuation
1692 Act.—

1693 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.—

1694 (b) Coverage under the group health plan must, at a
1695 minimum, extend for the period beginning on the date of the
1696 qualifying event and ending not earlier than the earliest of the
1697 following:

1698 1. The date that is 18 months after the date on which the
1699 qualified beneficiary's benefits under the group health plan
1700 would otherwise have ceased because of a qualifying event.

1701 2. The date on which coverage ceases under the group health
1702 plan by reason of a failure to make timely payment of the
1703 applicable premium with respect to any qualified beneficiary.

1704 3. The date a qualified beneficiary becomes covered under
1705 any other group health plan, ~~if the qualified beneficiary will~~
1706 ~~not be subject to any exclusion or limitation because of a~~
1707 ~~preexisting condition of that beneficiary.~~

1708 4. The date a qualified beneficiary is entitled to benefits
1709 under either part A or part B of Title XVIII of the Social
1710 Security Act (Medicare).

1711 5. The date on which the employer terminates coverage under

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1712 the group health plan for all employees. If the employer
1713 terminates coverage under the group health plan for all
1714 employees and if such group health plan is replaced by similar
1715 coverage under another group health plan, the qualified
1716 beneficiary shall have the right to become covered under the new
1717 group health plan for the balance of the period that she or he
1718 would have remained covered under the prior group health plan. A
1719 qualified beneficiary is to be treated in the same manner as an
1720 active beneficiary for whom a qualifying event has not taken
1721 place.

1722 Section 26. Subsection (1) of section 627.66997, Florida
1723 Statutes, is amended to read:

1724 627.66997 Stop-loss insurance.—

1725 (1) A self-insured health benefit plan established or
1726 maintained by a small employer, as defined in s. 627.6699(3) ~~s.~~
1727 ~~627.6699(3)(v)~~, is exempt from s. 627.6699 and may use a stop-
1728 loss insurance policy issued to the employer. For purposes of
1729 this subsection, the term "stop-loss insurance policy" means an
1730 insurance policy issued to a small employer which covers the
1731 small employer's obligation for the excess cost of medical care
1732 on an equivalent basis per employee provided under a self-
1733 insured health benefit plan.

1734 (a) A small employer stop-loss insurance policy is
1735 considered a health insurance policy and is subject to s.
1736 627.6699 if the policy has an aggregate attachment point that is
1737 lower than the greatest of:

- 1738 1. Two thousand dollars multiplied by the number of
1739 employees;
- 1740 2. One hundred twenty percent of expected claims, as

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1741 determined by the stop-loss insurer in accordance with actuarial
1742 standards of practice; or

1743 3. Twenty thousand dollars.

1744 (b) Once claims under the small employer health benefit
1745 plan reach the aggregate attachment point set forth in paragraph
1746 (a), the stop-loss insurance policy authorized under this
1747 section must cover 100 percent of all claims that exceed the
1748 aggregate attachment point.

1749 Section 27. Subsection (1), paragraph (b) and present
1750 paragraph (c) of subsection (2), and paragraph (c) of subsection
1751 (3) of section 627.6741, Florida Statutes, are amended to read:

1752 627.6741 Issuance, cancellation, nonrenewal, and
1753 replacement.—

1754 (1) (a) An insurer issuing Medicare supplement policies in
1755 this state shall offer the opportunity of enrolling in a
1756 Medicare supplement policy, without conditioning the issuance or
1757 effectiveness of the policy on, and without discriminating in
1758 the price of the policy based on, the medical or health status
1759 or preexisting conditions or receipt of health care by the
1760 individual:

1761 1. To any individual who is 65 years of age or older, or
1762 under 65 years of age and eligible for Medicare by reason of
1763 disability or end-stage renal disease, and who resides in this
1764 state, upon the request of the individual during the 6-month
1765 period beginning with the first month in which the individual
1766 has attained 65 years of age and is enrolled in Medicare Part B,
1767 or is eligible for Medicare by reason of a disability or end-
1768 stage renal disease, and is enrolled in Medicare Part B; or

1769 2. To any individual who is 65 years of age or older, or

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1770 under 65 years of age and eligible for Medicare by reason of a
1771 disability or end-stage renal disease, who is enrolled in
1772 Medicare Part B, and who resides in this state, upon the request
1773 of the individual during the 2-month period following
1774 termination of coverage under a group health insurance policy.

1775 (b) The 6-month period to enroll in a Medicare supplement
1776 policy for an individual who is under 65 years of age and is
1777 eligible for Medicare by reason of disability or end-stage renal
1778 disease and otherwise eligible under subparagraph (a)1. or
1779 subparagraph (a)2. and first enrolled in Medicare Part B before
1780 October 1, 2009, begins on October 1, 2009.

1781 (c) A company that has offered Medicare supplement policies
1782 to individuals under 65 years of age who are eligible for
1783 Medicare by reason of disability or end-stage renal disease
1784 before October 1, 2009, may, for one time only, effect a rate
1785 schedule change that redefines the age bands of the premium
1786 classes without activating the period of discontinuance required
1787 by s. 627.410(6)(e)2.

1788 (d) As a part of an insurer's rate filings, before and
1789 including the insurer's first rate filing for a block of policy
1790 forms in 2015, notwithstanding the provisions of s.
1791 627.410(6)(e)3., an insurer shall consider the experience of the
1792 policies or certificates for the premium classes including
1793 individuals under 65 years of age and eligible for Medicare by
1794 reason of disability or end-stage renal disease separately from
1795 the balance of the block so as not to affect the other premium
1796 classes. For filings in such time period only, credibility of
1797 that experience shall be as follows: if a block of policy forms
1798 has 1,250 or more policies or certificates in force in the age

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1799 band including ages under 65 years of age, full or 100-percent
 1800 credibility shall be given to the experience; and if fewer than
 1801 250 policies or certificates are in force, no or zero-percent
 1802 credibility shall be given. Linear interpolation shall be used
 1803 for in-force amounts between the low and high values. Florida-
 1804 only experience shall be used if it is 100-percent credible. If
 1805 Florida-only experience is not 100-percent credible, a
 1806 combination of Florida-only and nationwide experience shall be
 1807 used. If Florida-only experience is zero-percent credible,
 1808 nationwide experience shall be used. The insurer may file its
 1809 initial rates and any rate adjustment based upon the experience
 1810 of these policies or certificates or based upon expected claim
 1811 experience using experience data of the same company, other
 1812 companies in the same or other states, or using data publicly
 1813 available from the Centers for Medicaid and Medicare Services if
 1814 the insurer's combined Florida and nationwide experience is not
 1815 100-percent credible, separate from the balance of all other
 1816 Medicare supplement policies.

1817
 1818 A Medicare supplement policy issued to an individual under
 1819 subparagraph (a)1. or subparagraph (a)2. may not exclude
 1820 benefits based on a preexisting condition ~~if the individual has~~
 1821 ~~a continuous period of creditable coverage, as defined in s.~~
 1822 ~~627.6562(3), of at least 6 months as of the date of application~~
 1823 ~~for coverage. As used in this section, the term "preexisting~~
 1824 condition" has the same meaning as defined in s. 627.6487.

1825 (2) For both individual and group Medicare supplement
 1826 policies:

1827 ~~(b) If it is not replacing an existing policy, a Medicare~~

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1828 ~~supplement policy shall not limit or preclude liability under~~
1829 ~~the policy for a period longer than 6 months because of a health~~
1830 ~~condition existing before the policy is effective. The policy~~
1831 ~~may not define a preexisting condition more restrictively than a~~
1832 ~~condition for which medical advice was given or treatment was~~
1833 ~~recommended by or received from a physician within 6 months~~
1834 ~~before the effective date of coverage.~~

1835 (b) ~~(e)~~ If a Medicare supplement policy or certificate
1836 replaces another Medicare supplement policy or certificate or
1837 creditable coverage as defined in s. 627.6562(3), the replacing
1838 insurer shall waive any time periods applicable to ~~preexisting~~
1839 ~~conditions~~, waiting periods, elimination periods, and
1840 probationary periods in the new Medicare supplement policy for
1841 similar benefits to the extent such time was spent under the
1842 original policy.

1843 (3) For group Medicare supplement policies:

1844 (c) If a group Medicare supplement policy is replaced by
1845 another group Medicare supplement policy purchased by the same
1846 policyholder, the succeeding insurer shall offer coverage to all
1847 persons covered under the old group policy on its date of
1848 termination. Coverage under the new group policy may not result
1849 in any exclusion for preexisting conditions ~~that would have been~~
1850 ~~covered under the group policy being replaced.~~

1851 Section 28. Paragraph (d) of subsection (3) of section
1852 631.818, Florida Statutes, is amended to read:

1853 631.818 Powers and duties of the plan.—

1854 (3) The plan may appoint one or more HMOs in the same
1855 geographical area as defined in s. 641.19 to provide health care
1856 services, subject to all of the following conditions:

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1857 (d) Such coverage may ~~shall~~ not exclude a preexisting
1858 condition ~~not excluded by the policy of the insolvent HMO.~~

1859 Section 29. Paragraphs (f), (g), and (h) of subsection (1)
1860 of section 641.185, Florida Statutes, are amended to read:

1861 641.185 Health maintenance organization subscriber
1862 protections.—

1863 (1) With respect to the provisions of this part and part
1864 III, the principles expressed in the following statements serve
1865 as standards to be followed by the commission, the office, the
1866 department, and the Agency for Health Care Administration in
1867 exercising their powers and duties, in exercising administrative
1868 discretion, in administrative interpretations of the law, in
1869 enforcing its provisions, and in adopting rules:

1870 (f) A health maintenance organization subscriber should
1871 receive the flexibility to transfer to another Florida health
1872 maintenance organization, regardless of health status or
1873 preexisting conditions, pursuant to ss. 641.228, 641.3104,
1874 641.3107, 641.3111, 641.3921, and 641.3922. As used in this
1875 section, the term "preexisting condition" has the same meaning
1876 as defined in s. 641.31077.

1877 (g) A health maintenance organization subscriber should be
1878 eligible for coverage without discrimination against individual
1879 participants and beneficiaries of group plans based on health
1880 status pursuant to s. 641.31073 or based on preexisting
1881 conditions pursuant to s. 641.31077.

1882 (h) A health maintenance organization that issues a group
1883 health contract must: ~~provide coverage for preexisting~~
1884 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
1885 coverage pursuant to s. 641.31074; provide notice of

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1886 cancellation pursuant to s. 641.3108; provide extension of
 1887 benefits pursuant to s. 641.3111; provide for conversion on
 1888 termination of eligibility pursuant to s. 641.3921; and provide
 1889 for conversion contracts and conditions pursuant to s. 641.3922.

1890 Section 30. Paragraph (b) of subsection (5) of section
 1891 641.3007, Florida Statutes, is amended to read:

1892 641.3007 HIV infection and AIDS for contract purposes.—

1893 (5) RESTRICTIONS ON CONTRACT EXCLUSIONS AND LIMITATIONS.—

1894 (b) No health maintenance organization contract shall
 1895 exclude or limit coverage for exposure to the HIV infection or a
 1896 specific sickness or medical condition derived from such
 1897 infection, ~~except as provided in a preexisting condition clause.~~

1898 Section 31. Paragraph (c) of subsection (3) and subsections
 1899 (16) and (47) of section 641.31, Florida Statutes, are amended
 1900 to read:

1901 641.31 Health maintenance contracts.—

1902 (3)

1903 (c) The office shall disapprove any form filed under this
 1904 subsection, or withdraw any previous approval thereof, if the
 1905 form:

1906 1. Is in any respect in violation of, or does not comply
 1907 with, any provision of this part or rule adopted thereunder.

1908 2. Contains or incorporates by reference, where such
 1909 incorporation is otherwise permissible, any inconsistent,
 1910 ambiguous, or misleading clauses or exceptions and conditions
 1911 which deceptively affect the risk purported to be assumed in the
 1912 general coverage of the contract.

1913 3. Has any title, heading, or other indication of its
 1914 provisions which is misleading.

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1915 4. Is printed or otherwise reproduced in such a manner as
1916 to render any material provision of the form substantially
1917 illegible.

1918 5. Contains provisions which are unfair, inequitable, or
1919 contrary to the public policy of this state or which encourage
1920 misrepresentation.

1921 6. Excludes coverage for human immunodeficiency virus
1922 infection or acquired immune deficiency syndrome or contains
1923 limitations in the benefits payable, or in the terms or
1924 conditions of such contract, for human immunodeficiency virus
1925 infection or acquired immune deficiency syndrome which are
1926 different from ~~than~~ those that ~~which~~ apply to any other sickness
1927 or medical condition.

1928 7. Excludes coverage for a preexisting condition or
1929 contains limitations in the benefits payable for a preexisting
1930 condition. As used in this section, the term "preexisting
1931 condition" has the same meaning as defined in s. 641.31077.

1932 (16) The contracts must clearly disclose the intent of the
1933 health maintenance organization as to the applicability ~~or~~
1934 ~~nonapplicability~~ of coverage to preexisting conditions, as
1935 defined in s. 641.31077. ~~If coverage of the contract is not to~~
1936 ~~be applicable to preexisting conditions, the contract shall~~
1937 ~~specify, in substance, that coverage pertains solely to~~
1938 ~~accidental bodily injuries resulting from accidents occurring~~
1939 ~~after the effective date of coverage and that sicknesses are~~
1940 ~~limited to those which first manifest themselves subsequent to~~
1941 ~~the effective date of coverage.~~

1942 (47) (a) ~~As used in this subsection, the terms "operative~~
1943 ~~date" and "preexisting medical condition" have the same meanings~~

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1944 as provided in ~~s. 627.6046.~~

1945 ~~(b) A Not later than 30 days after the operative date, and~~
1946 ~~notwithstanding s. 641.31071 or any other law to the contrary,~~
1947 ~~every~~ health maintenance organization issuing, delivering, or
1948 issuing for delivery ~~comprehensive major medical~~ individual or
1949 group health maintenance contracts in this state ~~shall make at~~
1950 ~~least one comprehensive major medical health maintenance~~
1951 ~~contract available to residents in the health maintenance~~
1952 ~~organization's approved service areas of this state, and such~~
1953 ~~health maintenance organization~~ may not exclude, limit, deny, or
1954 delay coverage under such contract due to one or more
1955 preexisting ~~medical~~ conditions, as defined in s. 641.31077. A
1956 health maintenance organization may not limit or exclude
1957 benefits under such contract, including a denial of coverage,
1958 applicable to an individual as a result of information relating
1959 to an individual's health status before the individual's
1960 effective date of coverage, or if coverage is denied, the date
1961 of the denial.

1962 ~~(c) The comprehensive major medical health maintenance~~
1963 ~~contract the health maintenance organization is required to~~
1964 ~~offer under this section must be a contract that had been~~
1965 ~~actively marketed in this state by the health maintenance~~
1966 ~~organization as of the operative date and that was also actively~~
1967 ~~marketed in this state during the year immediately preceding the~~
1968 ~~operative date.~~

1969 Section 32. Subsection (2) of section 641.3102, Florida
1970 Statutes, is amended to read:

1971 641.3102 Restrictions upon expulsion or refusal to issue or
1972 renew contract.—

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1973 (2) A health maintenance organization may ~~shall~~ not expel
1974 or refuse to renew the coverage of, or refuse to enroll, any
1975 individual member of a subscriber group on the basis of the
1976 race, color, creed, marital status, sex, or national origin of
1977 the subscriber or individual. A health maintenance organization
1978 may ~~shall~~ not expel or refuse to renew the coverage of any
1979 individual member of a subscriber group on the basis of the age,
1980 health status, health care needs, preexisting condition as
1981 defined in s. 641.31077, or prospective costs of health care
1982 services of the subscriber or individual. ~~Nothing in~~ This
1983 section does not ~~shall~~ prohibit a health maintenance
1984 organization from requiring that, as a condition of continued
1985 eligibility for membership, dependents of a subscriber, upon
1986 reaching a specified age, convert to a converted contract or
1987 that individuals entitled to have payments for health costs made
1988 under Title XVIII of the United States Social Security Act, as
1989 amended, be issued a health maintenance contract for Medicare
1990 beneficiaries so long as the health maintenance organization is
1991 authorized to issue health maintenance contracts for Medicare
1992 beneficiaries.

1993 Section 33. Section 641.31073, Florida Statutes, is amended
1994 to read:

1995 641.31073 Prohibiting discrimination against individual
1996 participants and beneficiaries based on health status or
1997 preexisting conditions.—

1998 (1) Subject to subsection (2), a health maintenance
1999 organization that offers group health insurance coverage may not
2000 establish rules for eligibility, including continued
2001 eligibility, of an individual to enroll under the terms of the

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2002 contract based on any of the following health-status-related or
2003 preexisting-condition-related factors in relation to the
2004 individual or a dependent of the individual:

2005 (a) Health status.

2006 (b) Medical condition, including physical and mental
2007 illnesses.

2008 (c) Claims experience.

2009 (d) Receipt of health care.

2010 (e) Medical history.

2011 (f) Genetic information.

2012 (g) Evidence of insurability, including conditions arising
2013 out of acts of domestic violence.

2014 (h) Disability.

2015 (i) Preexisting condition.

2016
2017 As used in this section, the term "preexisting condition" has
2018 the same meaning as defined in s. 641.31077.

2019 (2) Subsection (1) does not:

2020 (a) Require a health maintenance organization to provide
2021 particular benefits other than those provided under the terms of
2022 such plan or coverage.

2023 (b) Prevent such a plan or coverage from establishing
2024 limitations or restrictions on the amount, level, extent, or
2025 nature of the benefits or coverage for similarly situated
2026 individuals enrolled in the plan or coverage.

2027 (3) For purposes of subsection (1), rules for eligibility
2028 to enroll under a contract include rules for defining any
2029 applicable affiliation or waiting periods of enrollment.

2030 (4) (a) A health maintenance organization that offers health

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2031 insurance coverage may not require any individual, as a
2032 condition of enrollment or continued enrollment under the
2033 contract, to pay a premium or contribution that is greater than
2034 such premium or contribution for a similarly situated individual
2035 enrolled under the contract on the basis of any health-status-
2036 related or preexisting-condition-related factor in relation to
2037 the individual or to an individual enrolled under the contract
2038 as a dependent of the individual.

2039 (b) This subsection does not:

2040 1. Restrict the amount that an employer may be charged for
2041 coverage under a group health insurance contract.

2042 2. Prevent a health maintenance organization offering group
2043 health insurance coverage from establishing premium discounts or
2044 rebates or modifying otherwise applicable copayments or
2045 deductibles in return for adherence to programs of health
2046 promotion and disease prevention.

2047 Section 34. Paragraph (f) of subsection (2) and paragraph
2048 (a) of subsection (3) of section 641.31074, Florida Statutes,
2049 are amended to read:

2050 641.31074 Guaranteed renewability of coverage.—

2051 (2) A health maintenance organization may nonrenew or
2052 discontinue a contract based only on one or more of the
2053 following conditions:

2054 (f) In the case of coverage that is made available only
2055 through one or more bona fide associations as defined in s.
2056 627.6571(5), the membership of an employer in the association,
2057 on the basis of which the coverage is provided, ceases, but only
2058 if such coverage is terminated under this paragraph uniformly
2059 without regard to any health-status-related or preexisting-

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2060 condition-related factor that relates to any covered
2061 individuals. As used in this section, the term "preexisting
2062 condition" has the same meaning as defined in s. 641.31077.

2063 (3) (a) A health maintenance organization may discontinue
2064 offering a particular contract form only if:

2065 1. The health maintenance organization provides notice to
2066 each contract holder provided coverage of this form in such
2067 market, and participants and beneficiaries covered under such
2068 coverage, of such discontinuation at least 90 days before ~~prior~~
2069 ~~to~~ the date of the nonrenewal of such coverage;

2070 2. The health maintenance organization offers to each
2071 contract holder provided coverage of this form in such market
2072 the option to purchase all, or in the case of the large group
2073 market, any other health insurance coverage currently being
2074 offered by the health maintenance organization in such market;
2075 and

2076 3. In exercising the option to discontinue coverage of this
2077 form and in offering the option of coverage under subparagraph
2078 2., the health maintenance organization acts uniformly without
2079 regard to the claims experience of those contract holders or any
2080 health-status-related or preexisting-condition-related factor
2081 that relates to any participants or beneficiaries covered or new
2082 participants or beneficiaries who may become eligible for such
2083 coverage.

2084 Section 35. Paragraph (a) of subsection (12) of section
2085 641.3903, Florida Statutes, is amended to read:

2086 641.3903 Unfair methods of competition and unfair or
2087 deceptive acts or practices defined.—The following are defined
2088 as unfair methods of competition and unfair or deceptive acts or

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2089 practices:

2090 (12) PROHIBITED DISCRIMINATORY PRACTICES.—A health
2091 maintenance organization may not:

2092 (a) Engage or attempt to engage in discriminatory practices
2093 that discourage participation on the basis of actual or
2094 perceived health status or actual or perceived preexisting
2095 condition, as defined in s. 641.31077, of Medicaid recipients.

2096 Section 36. Subsections (10) through (14) of section
2097 641.3922, Florida Statutes, are renumbered as subsections (9)
2098 through (13), respectively, and paragraphs (f) and (g) of
2099 subsection (7) and present subsection (9) of that section are
2100 amended, to read:

2101 641.3922 Conversion contracts; conditions.—Issuance of a
2102 converted contract shall be subject to the following conditions:

2103 (7) REASONS FOR CANCELLATION; TERMINATION.—The converted
2104 health maintenance contract must contain a cancellation or
2105 nonrenewability clause providing that the health maintenance
2106 organization may refuse to renew the contract of any person
2107 covered thereunder, but cancellation or nonrenewal must be
2108 limited to one or more of the following reasons:

2109 (f) A dependent of the subscriber has reached the limiting
2110 age under the converted contract, subject to subsection (11)
2111 ~~(12)~~; but the refusal to renew coverage shall apply only to
2112 coverage of the dependent, except in the case of handicapped
2113 children.

2114 (g) A change in marital status that makes a person
2115 ineligible under the original terms of the converted contract,
2116 subject to subsection (11) ~~(12)~~.

2117 ~~(9) PREEXISTING CONDITION PROVISION.—The converted health~~

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2118 ~~maintenance contract shall not exclude a preexisting condition~~
2119 ~~not excluded by the group contract. However, the converted~~
2120 ~~health maintenance contract may provide that any coverage~~
2121 ~~benefits thereunder may be reduced by the amount of any coverage~~
2122 ~~or benefits under the group health maintenance contract after~~
2123 ~~the termination of the person's coverage or benefits thereunder.~~
2124 ~~The converted health maintenance contract may also include~~
2125 ~~provisions so that during the first coverage year the coverage~~
2126 ~~or benefits under the converted contract, together with the~~
2127 ~~coverage or benefits under the group health maintenance~~
2128 ~~contract, shall not exceed those that would have been provided~~
2129 ~~had the individual's coverage or benefits under the group~~
2130 ~~contract remained in force and effect.~~

2131 Section 37. Section 627.6045, Florida Statutes, is
2132 repealed.

2133 Section 38. Section 627.6046, Florida Statutes, is
2134 repealed.

2135 Section 39. Section 627.6561, Florida Statutes, is
2136 repealed.

2137 Section 40. Section 627.65612, Florida Statutes, is
2138 repealed.

2139 Section 41. Section 641.31071, Florida Statutes, is
2140 repealed.

2141 Section 42. This act shall take effect January 1, 2021.