A bill to be entitled

An act relating to health care regulations; creating s. 381.02033, F.S.; establishing the Prescription Drug Affordability Commission within the Agency for Health Care Administration; providing a purpose; providing definitions; providing requirements for membership, terms of service, and meetings; requiring manufacturers to notify the commission of proposed price increases and introductory prices of prescription drugs under certain circumstances; providing notice requirements; requiring the commission to inform the public about manufacturer notices; providing requirements for reviews of prescription drug costs and determination of excess prescription drug costs; providing for determination of prescription drug rates under certain circumstances; providing penalties for noncompliance with specified requirements; providing exceptions; requiring the Office of the Attorney General to provide guidance to stakeholders concerning certain activities and transactions; authorizing certain persons to appeal the decision of the commission; authorizing public access to certain information; establishing an advisory council; providing requirements for membership and terms of service;

requiring the agency to provide the commission with staff; requiring commission and advisory council members and certain agency staff to recuse themselves if there are conflicts of interest; requiring disclosures of conflicts of interest; prohibiting acceptance of gifts, bequests, and donations; providing for per diem and travel expenses; requiring the commission to annually report specified information relating to prescription drug prices to the Governor and the Legislature; requiring the report to be posted on specified websites; providing rulemaking authority; amending s. 627.6487, F.S.; revising provisions relating to individual health insurance coverage for preexisting conditions; revising the definition of the term "preexisting condition"; deleting provisions authorizing insurers and health maintenance organizations to elect to limit specified coverage under certain circumstances; revising the conditions under which such insurers and health maintenance organizations may limit enrollment or deny coverage; revising construction; deleting obsolete language; creating s. 627.64875, F.S.; providing legislative intent; providing definitions; prohibiting specified health insurers from engaging in certain practices; requiring premium rates for

individual health insurance policies to be based on certain factors; prohibiting rate modifications within a specified timeframe; providing exceptions; providing applicability; providing rulemaking authority to the Financial Services Commission; creating s. 627.65613, F.S.; providing definitions; prohibiting specified insurers from declining to offer coverage under group, blanket, or franchise health insurance policies to certain groups, employers, and individuals; prohibiting such insurers from imposing preexisting condition exclusions; providing applicability; providing rulemaking authority; creating s. 627.65614, F.S.; providing definitions; prohibiting specified insurers from establishing, in their franchise health insurance policies, differentials in premium rates based on preexisting conditions; requiring premium rates for franchise health insurance policies to be based on certain factors; prohibiting rate modifications within a specified timeframe; providing exceptions; providing applicability; providing rulemaking authority; amending s. 627.6699, F.S.; revising legislative purpose and intent; revising the definition of the term "modified community rating"; defining the term "preexisting condition"; deleting provisions relating to preexisting condition

exclusions and limits; revising the geographic rating factors used by small employer carriers; prohibiting small employer carriers from varying premium rates based on preexisting conditions; revising the rating factors that small employer carriers must use to determine and vary premiums; providing requirements for the premium rates; revising the circumstances under which small employer carriers may modify premium rates within a specified period; prohibiting certain premium credits from being based on preexisting conditions; revising prohibited activities by small employer carriers; deleting obsolete language; deleting specified information that small employer carriers must disclose under certain circumstances; creating s. 641.1855, F.S.; providing definitions; prohibiting certain health maintenance organizations from establishing, in individual and small employer health maintenance contracts, differentials in premium rates based on preexisting conditions; requiring premium rates for such contracts to be based on certain factors; prohibiting rate modifications within a specified timeframe; providing exceptions; providing applicability; creating s. 641.31077, F.S.; providing legislative intent; providing definitions; prohibiting certain health maintenance organizations from

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

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:

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

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

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

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

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

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

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

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

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

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

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

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

recuses himself or herself under subsection (12).

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

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

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

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

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

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

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

shall serve 2 years.

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

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

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

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

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

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

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

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

1. Comment at a public meeting.

2. Submit written comments on a pending decision.

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

1. Reviewing a prescription drug cost analysis.

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

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

(4) REQUIRED MANUFACTURER NOTICES.—

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

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

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

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

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

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

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

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

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

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

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

(5) REVIEW OF PRESCRIPTION DRUG COSTS.—

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

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

(6) EXCESS COSTS TO PAYORS AND CONSUMERS.—

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

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

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

will be sold in the state.

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

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

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

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

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

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

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

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

10. Other such factors determined relevant by the commission.

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

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

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

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

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

(7) COMMISSION DETERMINATIONS; COMPLIANCE; REMEDIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

following:

1. The pharmaceutical business model.

2. Practice of medicine or clinical knowledge and training.

3. Patients' perspectives.

4. Health care cost trends and drivers.

5. Clinical and health services research.

6. The state health care marketplace in general.

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

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

a. Physicians

b. Nurses.

c. Hospitals.

d. Health insurers.

e. A statewide health care advocacy coalition.

f. A statewide senior advocacy coalition.

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

a. Pharmaceutical manufacturers.

b. Pharmaceutical employers.

c. Pharmacists.

d. Prescription drug research specialists.

e. The public.

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

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

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

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

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

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

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

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

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

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

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

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

c. The commission when:

(I) Being assisted by senior agency staff; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

term:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) An issuer, upon denying individual health insurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provided by s. 627.6475.

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

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

627.64875 Preexisting conditions; premium rates.—

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

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

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

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

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

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

defined in s. 627.6487.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) In tobacco use;

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

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

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

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

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

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

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

627.65613 Preexisting conditions.—

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

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

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

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

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

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

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

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

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

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

627.65614 Premium rates for franchise health insurance policies.—

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

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

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

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

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

(b) The geographic rating area that is established in

accordance with federal law.

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

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

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

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

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

(b) In tobacco use;

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

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

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

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

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

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

627.6699 Employee Health Care Access Act.—

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

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

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

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

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

(5) AVAILABILITY OF COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. A small employer carrier may not modify any health

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

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

plans.

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

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

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

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

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

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

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

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

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

b. In tobacco use;

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

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

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

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

covered under the policy if:

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

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

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

agent selling the policy.

6.~~5.~~ Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be

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

7.~~6.~~ A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

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

9.~~8.~~ A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

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

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

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

10.~~9.~~ A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

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

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

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

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

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

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

(13) DISCLOSURE OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

(a) "Health maintenance contract" means a health

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

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

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

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

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

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

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

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

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

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

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

(b) In tobacco use;

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

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

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

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

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

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

641.31077 Preexisting conditions.—

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

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

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

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

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

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

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

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

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

408.9091 Cover Florida Health Care Access Program.—

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

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

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

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

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

for services.

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

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

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

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

b. Incentives for routine preventive care.

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

d. Office surgery, including anesthesia.

e. Behavioral health services.

f. Durable medical equipment and prosthetics.

g. Diabetic supplies.

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

a. Inpatient hospital stays.

b. Hospital emergency care services.

c. Urgent care services.

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

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

9. Plan enrollment materials provide information in plain language on policy benefit coverage, benefit limits, cost-sharing requirements, and exclusions and a clear representation of what is not covered in the plan. Such enrollment materials must include a standard disclosure form adopted by rule by the Financial Services Commission, to be reviewed and executed by all consumers purchasing Cover Florida plan coverage.

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

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

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

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

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

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

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

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

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

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

(5) RESTRICTIONS ON COVERAGE EXCLUSIONS AND LIMITATIONS.—

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

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

627.607 Time limit on certain defenses.—

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

"Incontestable:

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

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

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

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

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

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

627.642 Outline of coverage.—

(2) The outline of coverage shall contain:

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

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

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

627.6425 Renewability of individual coverage.—

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

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

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

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

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

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

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

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

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

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

627.6426 Short-term health insurance.—

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

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

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

627.6475 Individual reinsurance pool.—

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

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

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

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

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

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

627.6525 Short-term health insurance.—

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

"This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Patient Protection and Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of ~~preexisting conditions or~~ health benefits (such as

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

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

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

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

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

(h) Disability.

(i) Preexisting condition.

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

(2) Subsection (1) does not:

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

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

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

(4)(a) An insurer that offers health insurance coverage may not require any individual, as a condition of enrollment or continued enrollment under the policy, to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled under the policy on the basis of any health-status-related or preexisting-condition-

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

(b) This subsection does not:

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

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

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

627.6571 Guaranteed renewability of coverage.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A group, blanket, or franchise health insurance policy that provides coverage for a family member of the certificateholder or subscriber shall, as to such family member's coverage, provide that benefits applicable to children of the certificateholder or subscriber also apply to an adopted child or a foster child of the certificateholder or subscriber placed in compliance with chapter 63, from the moment of placement in the residence of the certificateholder or subscriber. ~~Except in the case of a foster child,~~ The policy may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the certificateholder or subscriber before ~~prior to~~ the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in the residence of the certificateholder or subscriber in compliance with chapter 63.

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

627.6675 Conversion on termination of eligibility.—Subject

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

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

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

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

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

627.6692 Florida Health Insurance Coverage Continuation Act.—

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

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

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

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

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

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

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

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

Statutes, is amended to read:

627.66997 Stop-loss insurance.—

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

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

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

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

3. Twenty thousand dollars.

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

aggregate attachment point.

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

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) For group Medicare supplement policies:

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

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

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

631.818 Powers and duties of the plan.—

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

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

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

641.185 Health maintenance organization subscriber protections.—

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

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

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

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

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

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

641.3007 HIV infection and AIDS for contract purposes.—

(5) RESTRICTIONS ON CONTRACT EXCLUSIONS AND LIMITATIONS.—

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

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

641.31 Health maintenance contracts.—

(3)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

(h) Disability.

(i) Preexisting condition.

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

(2) Subsection (1) does not:

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

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

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

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

(b) This subsection does not:

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

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

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

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

641.31074 Guaranteed renewability of coverage.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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