A bill to be entitled

An act relating to government-facilitated purchases and sales of individual and small employer health and dental plans; creating s. 627.4463, F.S.; providing a short title; providing purpose and legislative intent; providing definitions; establishing the Florida Health Insurance Exchange within the Office of Insurance Regulation to facilitate purchase and sale of qualified health plans; providing duties of the exchange; authorizing the exchange to contract with an eligible entity to perform the exchange's functions under certain circumstances; authorizing the exchange to enter into agreements with governmental agencies and entities to carry out the exchange's responsibilities under certain circumstances; providing general requirements and prohibitions for the exchange; providing certifications by the exchange of health and dental benefit plans; authorizing the Commissioner of Insurance Regulation and the office to contract with a vendor to build and manage the exchange; providing rulemaking authority; providing construction; providing a contingent effective date.

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

Section 1. Section 627.4463, Florida Statutes, is created to read:

627.4463 Florida Health Insurance Exchange; government-facilitated purchases and sales of individual and small employer health and dental plans.—

(1) SHORT TITLE.—This section may be cited as the "Florida Health Insurance Exchange Act."

(2) PURPOSE AND INTENT.—The purpose of this section is to provide for the establishment of the Florida Health Insurance Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Florida Health Insurance Exchange is to reduce the number of uninsured persons, provide a transparent marketplace and consumer education, and assist persons with access to programs, premium assistance tax credits, and cost-sharing reductions.

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

(a) "Commissioner" means the Commissioner of Insurance Regulation.

(b) "Educated health care consumer" means a person who is knowledgeable about the health care system and has a background or experience in making informed decisions regarding health,

medical, and scientific matters.

(c) "Exchange" means the Florida Health Insurance Exchange established in this section.

(d)1. "Health benefit plan" means a policy, a contract, a certificate, or an agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

2. The term does not include:

a. Coverage only for accident, disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and motor vehicle liability insurance;

d. Workers' compensation or similar insurance;

e. Motor vehicle medical payment insurance;

f. Credit-only insurance;

g. Coverage for onsite medical clinics; or

h. Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

3. The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of

the plan:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

c. Other similar, limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

4. The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, if there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and if the benefits are paid with respect to an event without regard to whether the benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

a. Coverage only for a specified disease or illness; or

b. Hospital indemnity or other fixed indemnity insurance.

5. The term does not include the following if offered as a separate policy, certificate, or contract of insurance:

a. Medicare supplemental health insurance as defined in s. 1882(g)(1) of the Social Security Act;

b. Coverage supplemental to the coverage provided under chapter 55 of Title 10, U.S.C., the Civilian Health and Medical

Program of the Uniformed Services; or

c. Similar supplemental coverage provided to coverage under a group health plan.

(e) "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, which contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and health insurance company, a health maintenance organization, a nonprofit hospital and health service plan corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(f) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (7).

(g) "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

1. Has its principal place of business in this state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

2. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

(h) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in s. 1311(c) of PPACA and in subsection (7).

(i) "Qualified person" means a person, including a minor, who meets all of the following conditions:

1. Is seeking to enroll in a qualified health plan offered to persons through the exchange.

2. Resides in this state.

3. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

4. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(j) "Secretary" means, except when the context clearly indicates otherwise, the Secretary of the United States Department of Health and Human Services.

(k) "SHOP Exchange" means the Small Business Health Options Program established under subsection (6).

(l) "Small employer" has the same meaning as in s. 627.6699(3).

(4) ESTABLISHMENT OF THE FLORIDA HEALTH INSURANCE EXCHANGE.—

(a) The Florida Health Insurance Exchange is established

as a governmental entity within the Office of Insurance Regulation. To that end, the exchange shall strive to increase the availability of affordable health insurance in this state, while achieving efficiencies and economies and while providing service to policyholders. It is the intent of the Legislature that the exchange be an integral part of this state and that the income of the exchange be exempt from federal income taxation. The exchange shall operate pursuant to a plan of operation approved by order of the commissioner. The plan is subject to continuous review by the office. The office may, by order, withdraw approval of all or part of a plan if the commissioner determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan.

(b) The exchange must:

1. Facilitate the purchase and sale of qualified health plans.

2. Provide for the establishment of a SHOP Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans.

3. Meet the requirements of this section and any rules and regulations implemented under this section.

(c) The exchange may contract with an eligible entity for any of the exchange's functions described in this section. An eligible entity includes, but is not limited to, an entity that

has experience in individual and small group health insurance benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

(d) The exchange may enter into information-sharing agreements with federal and state agencies and exchanges in other states to carry out its responsibilities under this section, provided that such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

(5) GENERAL REQUIREMENTS.—

(a) The exchange must make qualified health plans available to qualified persons and qualified employers beginning January 1, 2028.

(b)1. The exchange may not make available any health benefit plan that is not a qualified health plan.

2. The exchange must allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of s. 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits that meet the requirements of s. 1302(b)(1)(J) of PPACA.

(c) Neither the exchange nor a carrier offering health benefit plans through the exchange may charge a person a fee or penalty for termination of coverage if the person enrolls in another type of minimum essential coverage because the person has become newly eligible for that coverage or because the person's employer-sponsored coverage has become affordable under the standards of s. 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(6) DUTIES OF THE EXCHANGE.—The exchange must:

(a) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under s. 1311(c) of PPACA and with subsection (7), of health benefit plans as qualified health plans.

(b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(c) Provide for enrollment periods, as provided under s. 1311(c)(6) of PPACA.

(d) Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

(e) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under s. 1311(c)(3) of PPACA and determine each qualified health plan's level of coverage in accordance with

regulations issued by the Secretary under s. 1302(d)(2)(A) of PPACA.

(f) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under s. 2715 of the Public Health Service Act.

(g) In accordance with s. 1413 of PPACA, inform persons of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, the Children's Health Insurance Program under Title XXI of the Social Security Act, or any applicable state or local public program and, if through screening of the application by the exchange, the exchange determines that any person is eligible for any such program, enroll that person in that program.

(h) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under s. 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under s. 1402 of PPACA.

(i) Establish a SHOP Exchange through which a qualified employer may access coverage for its employees, which must enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage.

(j) Subject to s. 1411 of PPACA, grant a certification attesting that, for purposes of the individual responsibility penalty under s. 5000A of the Internal Revenue Code of 1986, a person is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

1. There is no affordable qualified health plan available through the exchange, or the person's employer, covering the person; or

2. The person meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(k) Transfer to the United States Secretary of the Treasury the following:

1. A list of persons who are issued a certification under paragraph (j), including the name and taxpayer identification number of each person.

2. The name and taxpayer identification number of each person who was an employee of an employer but who was determined to be eligible for the premium tax credit under s. 36B of the Internal Revenue Code of 1986 because:

a. The employer did not provide minimum essential coverage; or

b. The employer provided the minimum essential coverage, but the coverage was determined under s. 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee

or not provide the required minimum actuarial value.

3. The name and taxpayer identification number of:

a. Each person who notifies the exchange under s. 1411(b)(4) of PPACA that he or she has changed employers.

b. Each person who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(l) Provide to each employer the name of each employee of the employer described in subparagraph (k)2. who terminates coverage under a qualified health plan during a plan year and the effective date of the termination.

(m) Perform duties required of the exchange by the Secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(n) Select entities qualified to serve as navigators in accordance with s. 1311(i) of PPACA and standards developed by the Secretary, and award grants to enable navigators to:

1. Conduct public education activities to raise awareness of the availability of qualified health plans.

2. Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under s. 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under s. 1402 of PPACA.

3. Facilitate enrollment in qualified health plans.

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under s. 2793 of the Public Health Service Act, or any other appropriate state agency, for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan or coverage or a determination under that plan or coverage.

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the exchange.

(o) Review the rate of premium growth within the exchange and outside the exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(p) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with s. 10108 of PPACA, and collect the amount credited from the offering employer.

(q) Consult with stakeholders relevant to carrying out the activities required under this section, including, but not limited to:

1. Educated health care consumers who are enrollees in qualified health plans.

2. Persons and entities with experience in facilitating

enrollment in qualified health plans.

3. Representatives of small businesses and self-employed persons.

4. The Secretary of Health Care Administration.

5. Advocates for enrolling hard-to-reach populations.

(r) Meet the following financial integrity requirements:

1. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the commissioner, and the Legislature a report concerning such accountings.

2. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under PPACA and allow the Secretary, in coordination with the Office of Inspector General for the United States Department of Health and Human Services, to:

a. Investigate the affairs of the exchange.

b. Examine the properties and records of the exchange.

c. Require periodic reports in relation to the activities undertaken by the exchange.

3. In carrying out its activities under this section, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

(7) HEALTH AND DENTAL BENEFIT PLAN CERTIFICATION.—

(a) The exchange may certify a health benefit plan as a qualified health plan if all of the following conditions are met:

1. The plan provides the essential health benefits package described in s. 1302(a) of PPACA, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in paragraph (e), if all the following conditions are met:

a. The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage.

b. The carrier makes prominent disclosure at the time the plan is offered, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange.

2. The premium rates and contract language have been approved by the office.

3. The plan provides at least a bronze level of coverage, as determined pursuant to paragraph (6)(e) unless the plan is certified as a qualified catastrophic plan, meets the requirements of PPACA for catastrophic plans, and will only be offered to persons eligible for catastrophic coverage.

4. The plan's cost-sharing requirements do not exceed the limits established under s. 1302(c)(1) of PPACA, and, if the

plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under s. 1302(c)(2) of PPACA.

5. The health carrier offering the plan meets all of the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this state.

b. Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the exchange in which the carrier participates, where the term "component" refers to the SHOP Exchange and the exchange for individual coverage.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of paragraph (5)(c).

e. Complies with the regulations developed by the Secretary under s. 1311(d) of PPACA and such other requirements as the exchange may establish.

6. The plan meets the requirements of certification as adopted by regulation pursuant to subsection (9) and by the Secretary under s. 1311(c) of PPACA, which include, but are not limited to, minimum standards in the areas of marketing

practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance.

7. The exchange determines that making the plan available through the exchange is in the interest of qualified persons and qualified employers in this state.

(b) The exchange may not exclude a health benefit plan:

1. On the basis that the plan is a fee-for-service plan;

2. Through the imposition of premium price controls by the exchange; or

3. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

(c) The exchange must require each health carrier seeking certification of a plan as a qualified health plan to do all of the following:

1. Submit a justification for any premium increase before implementation of that increase. The carrier must prominently post the information on its Internet website. The exchange must take this information, along with the information and the recommendations provided to the exchange by the commissioner under s. 2794(b) of the Public Health Service Act, into consideration when determining whether to allow the carrier to

make plans available through the exchange.

2.a. Make available to the public, in plain language as provided in subparagraph b., and submit to the exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(I) Claims payment policies and practices.

(II) Periodic financial disclosures.

(III) Data on enrollment.

(IV) Data on disenrollment.

(V) Data on the number of claims that are denied.

(VI) Data on rating practices.

(VII) Information on cost sharing and payments with respect to any out-of-network coverage.

(VIII) Information on enrollee and participant rights under Title I of PPACA.

(IX) Other information as determined appropriate by the Secretary.

b. The information required in subparagraph a. must be provided in plain language, as that term is defined in s. 1311(e)(3)(B) of PPACA.

3. Allow a person to learn, in a timely manner upon the request of the person, the amount of cost sharing, including deductibles, copayments, and coinsurance, under the person's plan or coverage which the person would be responsible for paying with respect to the furnishing of a specific item or

service by a participating provider. At a minimum, this information must be made available to the person through an Internet website and through other means for persons without access to the Internet.

(d) The exchange may not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and must apply the criteria of this section in a manner that is equitable between or among health carriers participating in the exchange.

(e)1. The provisions of this section that are applicable to qualified health plans also apply to the extent relevant to qualified dental plans, except as modified in accordance with subparagraphs 2., 3., and 4. or by regulations adopted by the exchange.

2. The carrier must be licensed to offer dental coverage but need not be licensed to offer other health benefits.

3. The plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and must include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to s. 1302(b)(1)(J) of PPACA and such other dental benefits as the exchange or the Secretary may specify by regulation.

4. Carriers may jointly offer a comprehensive plan through

the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

(8) VENDOR TO BUILD AND MANAGE EXCHANGE.—The commissioner and the office shall contract with a vendor selected by a competitive procurement to build and manage the exchange.

(9) RULEMAKING AUTHORITY.—The office may adopt rules and regulations to implement this section. Rules and regulations adopted under this section may not conflict with or prevent the application of regulations adopted by the Secretary under PPACA.

(10) RELATION TO OTHER LAWS.—This section, and any action taken by the exchange pursuant to this section, may not be construed to preempt or supersede the authority of the commission to regulate the business of insurance in this state. Except as expressly provided to the contrary in this section, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules and regulations adopted and orders issued by the commission.

Section 2. This act shall take effect July 1, 2026, but only if HB 1533 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.