The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/SB 1842
INTRODUCER:	Appropriations Committee and Banking and Insurance Committee
SUBJECT:	Health Insurance
DATE:	April 19, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Burgess		**BI SPB 7138 as Introduced**
2.	Shettle	Hansen	AP	**Fav/CS**
3.				
4.				
5.				
6.				

I. Summary:

CS/SB 1842 makes changes to the Florida Insurance Code related to the requirements of the federal Patient Protection and Affordable Care Act (PPACA) that apply to health insurers and health insurance policies.

The PPACA requires health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes extensive requirements on health insurers and health insurance policies including required benefits, rating and underwriting standards, required review of rate increases, and other requirements. The PPACA preempts any state law that prevents the application of a provision of the PPACA.

Each state may enforce the requirements of the PPACA, but if the U.S. Department of Health and Human Services (HHS) determines that a state has failed to substantially enforce any provisions, the HHS must enforce those provisions.

Currently, the Office of Insurance Regulation (OIR) reviews insurer and health maintenance organization (HMO) policy forms and rates and approves the forms and rates before they may be used by an insurer or HMO. The HHS is proposing to enter into a collaborative agreement with the OIR to specify the roles of the HHS and the OIR in the enforcement of the PPACA.

The overall fiscal impact of this bill for fiscal year 2013-2014 is $176,658. The sums of $106,658 in recurring funds and $70,000 in nonrecurring funds from the Insurance Regulatory Trust Fund are appropriated to the DFS to implement the provisions related to the registration of navigators.

The bill makes the following changes to the Florida Insurance Code:

- Provides that a provision of the Florida Insurance Code or rule adopted pursuant to the Code applies unless such provision or rule prevents the application of a provision of the PPACA. This is substantially the same preemption provision that is included in the PPACA.
- Authorizes the OIR to assist the HHS in enforcing the provisions of the PPACA by reviewing policy forms and performing market conduct examinations or investigations for compliance with the PPACA. The OIR must first notify the insurer of any non-compliance and then notify the HHS if the insurer does not take corrective action. This is similar to the "collaborative arrangement" that the HHS has already entered with the OIR, except that it does not authorize the OIR to review rates for compliance with the PPACA.
- Authorizes the Division of Consumer Services within the Department of Financial Services (DFS) to respond to complaints by consumers relating to requirements of the PPACA, by performing its current statutory responsibilities to prepare and disseminate information to consumers as it deems appropriate, provide direct assistance and advocacy to consumers, and require insurers to respond, in writing, to a complaint, and further authorizes the division to report apparent or potential violations to the OIR and to the HHS.
- Temporarily suspends the requirement that health insurers and HMOs (insurers) obtain approval from the OIR for nongrandfathered health plans (for which rates must be filed with the HHS) for plan years 2014 and 2015. Insurers would still be required to file rates and rate changes for such plans with the OIR prior to use, but such rates could be used without the OIR approval. For this two-year period, the rates for nongrandfathered plans would be exempt from all rating requirements. These rating law changes are repealed on March 1, 2015. Under the PPACA, insurers must file rate changes with the HHS for nongrandfathered health plans, subject to review and determination of whether the rate increase is unreasonable. Grandfathered health plans are not subject to the PPACA rate filing requirements and would remain subject to the current Florida law requirements for filing rates for approval with the OIR.
- Requires insurers to provide a notice to individual and small group policyholders of nongrandfathered health plans that describes or illustrates the estimated impact of the PPACA on monthly premiums. This notice would be required one time, when the policy is issued or renewed on or after January 1, 2014. The notice must be in a format established by rule by the Financial Services Commission. The OIR and the DFS must develop a summary of the estimated impact of the PPACA on monthly premiums as contained in the notices, which must be available on their respective websites by October 1, 2013.
- Makes the following changes that would allow or require insurers to take certain actions that would preserve the status of grandfathered health plans which, in general, are plans under which an individual was insured on March 23, 2010, and which are exempt from many of the requirements of the PPACA:
  - If a policy form covers both grandfathered health plans and nongrandfathered health plans, the bill allows an insurer to non-renew coverage only for all of the nongrandfathered health plans, subject to certain conditions.
  - Requires that the claims experience for grandfathered health plans be separated from nongrandfathered health plans for rating purposes, as also required by the PPACA.

  - Allows an insurer to discontinue a policy form that does not comply with the PPACA without being subject to the current prohibition on selling a new, similar policy form after a policy form is discontinued.
- Requires DFS registration of navigators, who are individuals who provide assistance and information to an individual regarding choices for enrollment in a qualified health plan (QHP) and facilitates enrollment in a QHP.
- Provides two different definitions of "small employer" – one for grandfathered health plans, which is the current law definition, and one for nongrandfathered health plans, which is the same as the federal definition used for the PPACA (but capped at 50 employees, as allowed by the PPACA). For nongrandfathered health plans, any state law that applies to small group coverage would apply to coverage for a small employer as defined under the PPACA and no longer would apply to an employer who is not a small employer under the federal definition.
- Requires the dissolution of the Florida Comprehensive Health Association (FCHA), which is the state's high risk pool for persons unable to obtain health insurance, by September 1, 2015. Coverage for the current 170 (approx.) FCHA policyholders would be terminated by June 30, 2014. The FCHA would be required to assist each policyholder in obtaining health insurance coverage.
- Specifies that health insurers and HMOs may nonrenew individual conversion policies if the individual is eligible for other similar coverage.
- Repeals the statute that establishes the Florida Health Insurance Plan, which has never been implemented.

This bill substantially amends the following sections of the Florida Statutes: 624.34, 627.402, 627.410, 627.411, 627.6425, 627.6484, 627.6571, 627.6675, 627.6699, 641.31, and 641.3922.

This bill creates the following sections of the Florida Statutes: 624.25, 624.26, 626.995, 626.9951, 626.9952, 626.9953, 626.9954, 626.9955, 626.9956, 626.9957, and 626.9958.

This bill repeals the following sections of the Florida Statutes: 627.64872, 627.648, 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499.

II. Present Situation:

Patient Protection and Affordable Care Act – Overview of Insurance Reforms

The federal PPACA was signed into law on March 23, 2010.[1] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases,

[1] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.[2]

The bill and this analysis address insurance provisions of the PPACA and Florida law that relate directly to the regulation of health insurers and HMOs. The bill and analysis do not address or affect Affordable Insurance Exchanges (Exchanges) that the PPACA requires to be established in each state, except as related to: (1) potential decertification of a Qualified Health Plan by an Exchange based on an unreasonable rate increase and (2) the role of navigators that obtain grants from Exchanges to provide certain consumer assistance activities. The bill and analysis do not address provisions of the PPACA related to the requirement that individuals obtain health insurance coverage; the requirement that employers offer health insurance coverage; Medicaid, Medicare, or other public programs; premium and cost-sharing subsidies to individuals; tax changes or financing of health reforms, or other provisions of the PPACA not directly related to insurance regulation.

PPACA – Limited Preemption of State Law

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[3] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[4] In the PPACA, Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of the PPACA.

Title I of the PPACA, which includes the requirements related to health insurance regulation, contains the following provision:

> No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[5]

Though expressed in the negative, the PPACA preempts any state law that prevents the application of a provision of the PPACA. The PPACA effectively allows states to adopt and enforce laws that provide greater consumer protections than the PPACA, but any state law that does not meet the federal minimum standards will be preempted. [6]

Many of Florida's insurance laws have less restrictive requirements than a comparable provision of the PPACA. Even though more restrictive PPACA requirements will control, state enforcement of a less restrictive provision does not prohibit an insurer from complying with a more restrictive provision of the PPACA and, as such, does not actually prevent the application of a provision of the PPACA. In those cases, the more relevant issue is whether the failure of the state to enforce the federal law triggers federal enforcement, which is addressed in a separate

[2] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg et seq.).
[3] U.S. Const. art. VI, cl. 2
[4] See, *West Florida Regional Medical Center v. See*, 79 So.3rd 1, at 15 (Fla. 2012)
[5] PPACA s. 1321(d)
[6] "Preemption and State Flexibility in PPACA" at:
http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf

provision of the PPACA and discussed immediately below. If, however, a state law has the effect of prohibiting an insurer from complying with the PPACA, then enforcement of that state law would actually prevent the application of a provision of the PPACA.

State and Federal Enforcement of the PPACA Insurance Requirements; OIR Collaborative Arrangement with the HHS

Currently, the OIR reviews insurer and HMO policy forms and rates and approves the forms and rates before they may be used by an insurer or HMO. The OIR also performs market conduct examinations and investigations of insurers and HMOS.

Each state may enforce the requirements of the PPACA and other requirements of the federal Public Health Services Act that apply to health insurance issuers, but if the Secretary of the HHS determines that a state has failed to substantially enforce any such provisions, the Secretary must enforce those provisions.[7] In such case, if the HHS determines that a health insurance issuer has failed to meet an applicable requirement (provided the issuer knew of such failure or would have known by exercising reasonable diligence), the HHS may impose a maximum civil monetary penalty of $100 for each day for each individual with respect to which such failure occurs.[8]

Under the HHS and its Centers for Medicare and Medicaid Services (CMS), the Center for Consumer Information & Insurance Oversight (CCIIO) oversees the implementation of the provisions of the PPACA related to insurance.[9]

The CCIIO has concluded that, the federal law contemplates that states will exercise primary enforcement authority of health insurance issuers to ensure compliance with health insurance market reforms.[10] If a state notifies the CMS that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more provisions of the PPACA, or if the CMS determines that the state is not substantially enforcing the requirements, the CMS has the responsibility to enforce these provisions in that state. The CCIIO has concluded that this responsibility may be met either through a collaborative arrangement with the state or by direct enforcement by the CMS. If the state does not enter into a collaborative agreement, the CMS will notify health insurance issuers in that state that they must submit policy forms to the CMS for review and the CMS will notify issuers of any concerns. The CMS will also conduct targeted market conduct examinations, as necessary, to respond to consumer inquiries and complaints to ensure compliance, and will work cooperatively with the state to address any concerns. At any time, a state may assume enforcement authority of PPACA market reform standards and the CMS will work with the state to ensure an effective transition. As of March 1, 2013, four states (Missouri, Oklahoma, Texas, and Wyoming) have notified the CMS that they do not have the authority to enforce or are not otherwise enforcing the PPACA provisions.

[7] PHSA s. 2722 (42 U.S.C. s. 300gg-22)
[8] Id
[9] http://cciio.cms.gov/index.html
[10] http://cciio.cms.gov/programs/marketreforms/Compliance/index.html

A letter[11] dated March 12, 2013, to Florida Insurance Commissioner Kevin McCarty, from a representative of the CMS, states that the OIR does not have direct enforcement authority for federal laws implementing the Affordable Care Act and other federal laws under title XXVII of the Public Health Services Act and that "...this letter serves as a means to accomplish HHS's direct enforcement through a collaborative arrangement with the State of Florida." The letter then specifies the details of the collaborative arrangement, as follows:

> **I. COLLABORATIVE ARRANGEMENT**
> It is important to both the Office and HHS that the elements of this collaborative arrangement be clearly described and delineated. Under this arrangement, the Office will perform the insurance compliance functions as specified below:
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> **A. Policy Form Review**
> The Office will review insurance policy forms for compliance with Florida laws and rules. Further, during that review, the Office will review applicable policy forms for compliance with all federal laws and regulations. If the Office determines that an insurer's form filing is not in compliance with the federal laws and regulations and is unable to obtain voluntary compliance, the Office will report potential violations of federal laws and regulations to HHS for appropriate formal enforcement action;
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> **B. Rate Review**
> The Office will review insurance policy rates for compliance with all Florida laws and rules and review for compliance with all federal laws and regulations. If the Office determines that an insurer's rate filing is not in compliance with federal laws and regulations and is unable to obtain voluntary compliance, the Office will report potential violations of federal laws and regulations to HHS for appropriate formal enforcement action; and
>
> **C. Perform Targeted Market Conduct Exams**
> The Office will perform market conduct examinations and investigations as warranted for compliance with all Florida laws and rules. During the examinations or investigations, the Office will review for compliance with federal laws and regulations. If the Office determines that an insurer's operations are not in compliance with federal laws and regulations and is unable to obtain voluntary compliance, the Office will report potential violations to HHS for appropriate formal enforcement action.

[11] Contained in the meeting materials for the March 18, 2013 meeting of the Senate Select Committee on the Patient Protection and Affordable Care Act at: http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2127.pdf

> This collaborative arrangement does not address, nor does it obligate the Office to perform consumer assistance functions on behalf of HHS. A separate agreement between HHS and the appropriate Florida consumer services agency will be necessary to address consumer assistance issues.
>
> The collaborative arrangement outlined above will become effective March 12, 2013. If the Florida Legislature adopts legislation giving the state direct enforcement authority for provisions consistent with the ACA and other federal laws under title XXVII of the PHS Act, the Office will notify HHS of this development. Until then, this letter will document our collaborative arrangement.

The letter notes that it does not address consumer assistance functions and that a separate agreement with the appropriate Florida consumer services agency will be necessary to address those issues, which is the agency discussed below.

(The PPACA contains provisions specific to the role of the HHS and the states to review rate increases, addressed in *Review of Insurer Premium Increases*, later in this analysis.)

Division of Consumer Services within the Department of Financial Services

The Division of Consumer Services is charged with the responsibility for responding to insurance complaints from consumers, as specified in s. 20.121(2)(h), F.S. For any product or service regulated by the DFS or the OIR, such as health insurance policies or HMO contracts regulated by the OIR, the division is required to:

- Receive inquiries and complaints from consumers;
- Prepare and disseminate such information as it deems appropriate to inform or assist consumers;
- Provide direct assistance and advocacy for consumers who request such assistance or advocacy; and
- With respect to apparent or potential violations of law or rules by a person licensed by the DFS or the OIR (such as a health insurer or HMO), report such apparent or potential violation to the appropriate division of the DFS or the OIR for further action.

Additionally, an insurer issued a certificate of authority by the OIR (or other licensee) is required to respond, in writing, to the division within 20 days after receipt of a written request for information concerning a complaint.

The statutory duties of the division related to providing information, assistance, and advocacy to consumers and requiring written responses from insurers are not expressly limited to complaints concerning violations of state insurance laws and may give discretion to the DFS to determine whether any of those functions are appropriate for PPACA-related complaints. However, the requirement to report potential violations of law to the OIR or the DFS would reasonably be limited to laws that the OIR or the DFS have authority to enforce and there is no reference to reporting violations to any federal agencies.

Grandfathered Health Plans

The PPACA exempts "grandfathered health plan coverage" from many of its insurance requirements (as specified in the summary of the key insurance provisions, below). For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule.[12] Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010.

The conditions for maintaining grandfathered status are specified in the rule. A statement must be included in any health plan materials provided to the insured describing the benefits that the coverage is believed to be a grandfathered health plan within the meaning of the PPACA and contact information must be provided for questions and complaints. The health plan must maintain records documenting the terms of the coverage in effect on March 23, 2010, and any other documents necessary to verify its status as a grandfathered health plan.

A health plan does not lose grandfathered status due solely to any of the following reasons (among others):

- One or more individuals enrolled on March 23, 2010, cease to be covered, provided that the health plan has continuously covered someone since that date;
- Family members enroll after March 23, 2010, in the grandfathered coverage of an individual;
- New employees enroll after March 23, 2010, in the grandfathered coverage of an employer.

A health plan loses grandfathered status, if any of the following changes are made to the plan (among others):

- The elimination of all or substantially all benefits to diagnose or treat a particular condition;
- Any increase in a percentage cost-sharing requirement, such as an individual's coinsurance requirement;
- Any increase in a fixed-amount cost-sharing requirement other than a copayment, such as a deductible or out-of-pocket limit;
- Any increase in a fixed-amount copayment that exceeds a specified (by rule) amount;
- For a group plan, any decrease in the contribution rate by the employer by more than 5 percentage points;
- Adding an annual or lifetime dollar limit or reducing such limits.

Although not specifically addressed by rule, a plan may add benefits without causing a loss of grandfathered status. Even though grandfathered plans were exempt from many of the PPACA insurance benefit requirements that were effective on September 23, 2010, some insurers have

[12] PPACA s. 1251; 42 U.S.C. s. 18011; 45 C.F.R. s. 147.140

reportedly added those benefits to grandfathered plans without causing those plans to lose grandfathered status.

The most significant changes of the PPACA take effect for plan years beginning 2014, which are the changes that are expected to have the biggest impact on premiums. Assuming that insurers do not add all newly required benefits to grandfathered health plans or take other actions that cause a plan to lose grandfathered status, the requirement of the PPACA to separate claims experience of grandfathered and nongrandfathered health plans will generally insulate grandfathered health plans from the premium impact of the 2014 changes, especially the impact of guaranteed issue requirements that require insurers to offer coverage to all individuals and employers, regardless of their health status. However, the legal authority for insurers to take certain actions to segregate nongrandfathered policies may be affected by certain federal and state laws, which are discussed immediately below.

Nonrenewal of Health Insurance Policies; Discontinuance of Policy Forms

Florida law requires that individual health insurance policies be guaranteed renewable, subject to certain exceptions.[13] One exception is that an insurer may discontinue offering a particular policy form for health insurance coverage in the individual market, but only if the insurer provides 90 days notice of nonrenewal, offers to each individual the option to purchase any other individual health insurance coverage currently being offered, and acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage.[14] Substantially the same requirements are provided for group health insurance policies.[15] This Florida law is closely modeled on federal law.[16]

A related Florida law provides that an insurer that discontinues the availability of a policy form must provide 30 days notice to the OIR and the insurer is thereafter prohibited from offering the policy form for sale in Florida and prohibited from filing for approval a new policy form providing similar benefits for 5 years.[17]

Definition of "Small Employer"

Florida law requires health insurers and HMOs in the small group market to offer coverage to all small employers on a guaranteed-issue basis, as provided in the Employee Health Care Access Act.[18] This requirement and all other provisions in the Florida Insurance Code that apply to small group coverage are based on the definition of "small employer" in this act.[19] In summary, a "small employer" means any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has it principal place of business in this state, and employs an average of at least 1 but not more than

[13] S. 627.6425, F.S.
[14] Section 627.6425(3), F.S.
[15] S. 627.6571, F.S.
[16] 42 U.S.C. 300gg-2(c)(1)
[17] S. 627.410(6)(e), F.S.
[18] S. 627.6699, F.S.
[19] S. 627.6699(3)(v), F.S.

50 "eligible employees." An "eligible employee," is defined as an employee who works full time and has a normal workweek of 25 or more hours.[20]

Under the PPACA, a "small employer" is defined differently than under Florida law.[21] Under federal law, a "small employer" is an employer that employs an average of at least 1 but not more than 100 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. However, the PPACA allows states to cap the number of employees at 50. The federal definition of "employee" is simply an individual employed by an employer.[22]

Florida's definition of small employer includes sole proprietors and other individuals who are not small employers under the PPACA. PPACA requirements for individual health insurance coverage would apply to coverage for such individuals. Many requirements of the PPACA are the same for individual and small group coverage, but some are not. For example, the PPACA requires that for rating purposes that claims experience for all individual, small group, and large group policies must be pooled separately. Florida's definition of small employer also includes employers that are considered large employers under the PPACA, by only counting "eligible employees" who work at least 25 hours per week. The PPACA has some requirements that are the same for small group and large group policies, but some are different. In general, federal law will supersede or preempt state law for many of these requirements, but those determinations may not always be clear and having different definitions of small employer is a further complication for policy administration by insurers.

Since grandfathered health plans are exempt from many of the PPACA requirements, the differing state and federal definition of small employer poses fewer problems, but this issue still arises for provisions of the PPACA that apply to grandfathered policies.

Key Insurance Provisions of the PPACA; Comparable State Insurance Laws

The PPACA insurance provisions were phased-in beginning in 2010, but the most dramatic changes become effective January 1, 2014. The PPACA applies these requirements to "health insurance issuers" which includes both health insurers and HMOs, and applies to both group and individual health insurance coverage, except where otherwise noted. This analysis uses the terms, "health insurers" and "health insurance policies" to include HMOs and HMO contracts, except where a distinction is noted, and includes both individual and group coverage, except where otherwise noted.

The key PPACA insurance provisions and comparable requirements of Florida law are summarized below, grouped in order of the federal law effective dates. As discussed above, if state law requirements are less restrictive and provide less consumer protection than a provision of the PPACA, the federal law will control, which applies to most of these provisions. In some cases, Florida law is more restrictive and provides greater consumer protections, in which case state law will control. If a grandfathered health plan is exempt from a PPACA requirement, only the state law applies to such plans.

[20] S. 627.6699(3)(h), F.S.
[21] 42 U.S.C. 300gg-91(e)(4)
[22] 29 U.S.C. 1002, as referenced by 42 U.S.C. s. 300gg-91(d)(5)

In still other cases, federal and state laws impose different requirements for similar purposes and the question is which requirements of state law "prevent the application" of a provision of the PPACA and are preempted, which federal and state regulators must determine and may ultimately require a judicial determination or further state or federal legislation to resolve.

The following requirements of the PPACA apply to health insurance policies that have plan years beginning on or after September 23, 2010:

Lifetime and Annual Dollar Limits[23] – Health insurance policies are prohibited from having lifetime limits on the dollar value of essential health benefits. (See *Essential Health Benefits*, below.) Grandfathered health plans are not exempt from this requirement. The federal law also prohibits health insurance policies from having annual limits on the dollar value of essential health benefits that are less than: $750,000 for plan years beginning on or after 9/23/2010; $1.25 million for plan years beginning on or after 9/23/2011; or $2 million for plan years beginning on or after 9/23/2012. For plan years on or after 1/1/2014, no annual limit on the dollar value of essential health benefits is allowed. Individual (but not group) grandfathered health plans are exempt from the annual limit restrictions.

Florida law does not have any comparable requirement that prohibits insurers from imposing annual or lifetime limits, but laws that mandate certain benefits allow or require annual or lifetime dollar limits.[24]

Rescissions[25]- A health insurer may not rescind (meaning retroactively cancel) coverage except for fraud or intentional misstatement of a material fact, as prohibited by the terms of the policy. The insurer must provide at least 30 days advance written notice of rescission to the policyholder. This does not prohibit retroactive cancellation to the extent that it is due to failure to timely pay required premiums. Grandfathered health plans are not exempt from this requirement.

Florida law provides that for individual health policies, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for a loss incurred after the 2-year period. Alternatively, the policy may have an incontestability provision that after the policy has been in force for 2 years, the insurer cannot contest the statements in the application.[26] For group health policies, Florida law provides that in the absence of fraud, all statements made by applicants are deemed representations and not warranties and no statement shall avoid (void) the insurance or reduce benefits unless contained in a signed, written statement.[27] For HMO contracts, after 2 years from the issue date, only fraudulent misstatement in the application may be used to void the policy or deny any claim for loss incurred after the 2-year period.[28]

[23] PPACA s. 1001; PHSA s. 2711 (42 U.S.C. s. 300gg-11)
[24] For example, mandatory coverage for autism requires a $36,000 annual limit and a $200,000 lifetime limit on such benefits; ss. 627.6686 and 641.3198, F.S.
[25] PPACA s. 1001; PHSA s. 2712 (42 U.S.C. s. 300gg-12)
[26] S. 627.607, F.S.
[27] S. 627.657, F.S.
[28] S. 641.31(23), F.S.

Coverage of Preventive Health Services[29]- The PPACA requires coverage without cost-sharing, with certain exceptions, for:

- Services recommended by the U.S. Preventive Services Task Force (except for current breast cancer screening recommendation, which reverts to prior recommendation);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women supported by the Health Resources and Services Administration.

Grandfathered health plans are exempt from these requirements.

Florida law requires health insurance policies to provide coverage for wellness benefits for children from birth to age 16, which must be exempt from any deductible, including a physical examination, immunizations and laboratory tests consistent with Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, newborn coverage, and newborn hearing screening.[30]

Florida law requires coverage of a mammogram for a woman at specified age levels.[31]

Florida law requires HMOs and health insurers that provide coverage through exclusive providers to provide coverage, without prior authorization, for one annual visit with a contracted OB/GYN. [32]

Adult Dependent Coverage[33] - The PPACA requires policies that provide dependent coverage to extend coverage to adult children until age 26. The policy may not define dependent for purposes of eligibility for dependent coverage other than in terms of the relationship between the child and the dependent (which prohibits such conditions as financial dependency, student status, living at home, or not being married). For plan years beginning before 1/1/2014, a grandfathered group health plan may exclude coverage for an adult child under age 26 who is eligible for other employer-sponsored coverage.

Florida law requires health insurance policies offering dependent coverage to insure a dependent child until the end of the year in which the child reaches the age of 25 if the child is dependent for support and is either living in the household or is a full-time student. The Florida law also requires policies to offer the option to insure a child until the end of the calendar year in which the child reaches the age of 30 if the child is unmarried and does not have a dependent, is either a

[29] PPACA s. 1001; PHSA s. 2713 (42 U.S.C. s. 300gg-13)
[30] SS. 627.6416 (individual), 627.6579 (group), 627.6699(12)(b)4. (small group), and 641.31(30) (HMO), F.S.
[31] SS.627.6418 (individual), 627.6613 (group), 627.6699(12)(b)4. (small group), and 641.31095 (HMO), F.S.
[32] SS. 627.6472(18) (individual EPO), 627.662(9) (group EPO), and 641.31(27) (HMO), F.S.
[33] PPACA s. 1001; PHSA s. 2714 (42 U.S.C. s. 300gg-14)

Florida resident or student, is not provided coverage by any other plan, and is not eligible for Medicaid.[34]

Pre-Existing Condition Exclusion for Children Under Age 19[35] - The PPACA prohibits health insurance policies from excluding coverage for a pre-existing condition for children under age 19. As interpreted by rules adopted by the HHS, the definition of "preexisting condition exclusion" includes a denial of coverage.[36] Individual (but not group) grandfathered health plans are exempt from this requirement.

The Florida law on preexisting condition exclusions is summarized under the broader prohibitions of the PPACA effective for plan years beginning 1/1/2014, below.

Internal and External Review Process[37]- The PPACA requires health insurers to implement an internal appeals and independent external review process. For the internal appeals process, group plans must incorporate the U.S. Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by the HHS. These regulations include notice requirements for the initial benefit determination itself, as well as requirements for allowing claimants to appeal an adverse benefit determination to the insurer and the internal review process that insurers must follow.

For the external review process, all plans must comply with applicable state external review processes that, at a minimum, includes consumer protections in the NAIC Uniform Health Carrier External Review Model Act (April, 2010) or with minimum standards established by the HHS that are similar to the NAIC model.

Grandfathered health plans are exempt from these federal requirements.

Florida law enacted in 2012 requires individual and group insurance policies to comply with internal grievance procedures of the U.S. Department of Labor (but cited regulations are not the updated version).[38] The 2012 act also authorized the OIR to adopt rules to administer the NAIC Uniform Health Carrier External Review Model Act (April, 2010), which rules have not yet been adopted and must be approved by the Financial Services Commission.[39] The act also provided that the Subscriber Assistance Program, which provided external review determinations on grievances against HMOs and health insurer exclusive provider organizations (and certain other prepaid plans), now applies only to those HMO and insurer plans that meet the requirements of cited federal regulations for status as a grandfathered health plan, unless the plan elects to have

[34] SS. 627.602 (individual), 627.6562 (group), and 641.31(41) (HMO), F.S.
[35] PPACA s. 1201 (PHSA s. 2704), as amended by s. 2301 of P.L. 111-152
[36] 45 C.F.R. s. 144.103
[37] PPACA s. 1001; PHSA s. 2719 (42 U.S.C. s. 300gg-19); 45 C.F.R. s. 147.136
[38] Ch. 2012-44, L.O.F.; ss. 627.602(1)(h) and 627.6513, F.S. These sections subject individual and group policies, respectively, to the Dept. of Labor regulation, 29 C.F.R. s. 2560.503-1, relating to internal grievances. However, this does not incorporate the requirements for internal appeals adopted by HHS in 45 C.F.R. s. 147.136, also adopted by the Dept. of Labor in 29 C.F.R. s. 2590.715-2719.
[39] Section 641.312, F.S.; Also see, ss. 627.602(1)(h) and 627.6513, F.S.

all of its policies or contracts subject to applicable internal grievance and external review process by an independent review organization.[40]

Florida law also requires individual health insurance policies to provide a claimant or their provider who has a claim denied as not medically necessary with the opportunity for an appeal to the insurer's physician responsible for medical necessity reviews.[41] HMOs must have an internal grievance procedure meeting specified requirements.[42]

Emergency Room Coverage[43] – The PPACA requires that coverage for emergency services must be provided without prior authorization, regardless of whether the provider is a network provider. Services provided by non-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. Regulations specify minimum reimbursement that plans must pay a non-network provider for emergency services.[44] Grandfathered health plans are exempt from these requirements.

Florida law requires HMOs to provide coverage without prior authorization for emergency care, based on a determination by a hospital physician or other personnel, provided by either a contract or non-contract provider. Insurers and HMOs may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. HMOs must pay non-contract providers specified minimum reimbursement for emergency services. Insurers issuing exclusive provider contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.[45]

Primary Care Physicians and OB/GYN Coverage[46]–The PPACA requires a policy that requires policyholders to designate a primary care provider to allow the choice of any participating primary care provider who is available to accept them. For a child, the policy must allow the parent to choose any participating pediatrician. A policy may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider. Grandfathered health plans are exempt from these requirements.

Florida law requires HMOs to give subscribers a choice of a primary physician who is an allopathic physician, osteopath, chiropractor, or podiatrist. A female subscriber may select an OB/GYN as her primary care physician.[47] Florida law requires HMOs and insurers issuing

[40] S. 408.7056(15), F.S.
[41] S. 627.6141, F.S.
[42] S. 641.511, F.S.
[43] PPACA s. 1001; PHSA s. 2719A (42 U.S.C. s. 300gg-19A)
[44] 45 C.F.R. s. 147.138(b)
[45] S. 641.513, 631.31(12), and 627.6472, F.S.
[46] PPACA s. 1001; PHSA s. 2719A (42 U.S.C. s. 300gg-19A)
[47] S. 641.19(12)(e), F.S.

exclusive provider contracts to allow insureds, without prior authorization, to visit a contracted OB/GYN for one annual visit and for medically necessary follow-up care.[48]

The following requirements of the PPACA affecting health insurance premiums apply to health insurance policies with plan years beginning on or after 1/1/2010 or 1/1/2011, as specified:

Review of Insurer Premium Increases[49]–For policies with plan years beginning 1/1/2010, the PPACA requires the HHS, in conjunction with the states, to develop a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The process must require insurers to submit to the state and the HHS a justification for an unreasonable premium increase prior to implementation. For policies with plan years beginning 1/1/2014, the HHS, in conjunction with the states, must monitor premium increases of health insurance coverage offered through an Exchange and outside an Exchange. Grandfathered policies are exempt from these requirements.

Rules adopted by the HHS specify requirements for the rate review process.[50] If any individual or small group market product is subject to a rate increase, a health insurer must submit a rate filing justification in a specified format to the CMS (under the HHS) for all products in the individual or small group market, respectively, including new or discontinuing products.[51] A rate increase of 10 percent or more or which exceeds an applicable state-specified threshold is subject to CMS review.[52] In determining whether a rate increase is unreasonable, the CMS will rely on a state's determination if the state has an effective rate review program, based on specified criteria.[53] As of March 29, 2013, the CMS has determined that Florida has an effective rate review program for both the individual and small group market (but only "partially" effective for individual association products), and is one of 43 states that have effective rate review programs for at least one market. [54]

When the CMS reviews a rate increase of 10 percent or more, it will determine that the rate increase is unreasonable if it is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.[55] The rate increase is an excessive rate increase if it causes the premium charged to be unreasonably high in relation to the benefits provided, based on whether the rate increase results in a projected medical loss ratio (MLR) below the federal MLR standard, whether any assumptions are not supported by substantial evidence, and whether the choice or combination of assumptions is unreasonable. The rate increase is unjustified if the insurer provides data that is incomplete, inadequate or does not provide a basis upon which the reasonableness of an increase may be determined. The rate increase is unfairly discriminatory if it results in premium differences between insureds within similar risk categories that are not

[48] SS. 627.6472(18) (individual EPO), 627.662(9) (group EPO), and 641.31(27) (HMO), F.S.
[49] PPACA s. 1003; s. 2794 of PHSA (42 U.S.C. s. 300gg-94)
[50] 45 C.F.R. Part 154, as amended by final rules published in 78 F.R. 13406 (Feb. 27, 2013) , hereafter referenced as 2/27/13 final rules.
[51] 45 C.F.R. ss. 154.101 and 154.215, as amended by 2/27/13 final rules.
[52] 45 C.F.R. ss. 154.200 and 154.210(a)
[53] 45 C.F.R. ss. 154.225(b) and 154.301
[54] http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html
[55] 45 C.F.R. s. 154.205

permissible under applicable state law or, in the absence of such state law, do not reasonably correspond to differences in expected rates.

If the CMS determines that a rate increase is unreasonable, it does not have authority to disapprove the rate increase, but it will post on its website[56] its final determination and a brief explanation of its analysis.[57] If a health insurer implements a rate increase determined to be unreasonable, the health insurer must prominently post on its website the CMS (or the state's) final determination and the health insurer's preliminary and final justification, which must be posted for at least 3 years.[58]

The PPACA also requires that an Exchange must require health insurers seeking certification of qualified health plans (QHPs) to submit a justification of any premium increase prior to implementation. The Exchange must take the information into consideration, including recommendations provided to the Exchange by the state, when determining whether to certify the QHP and make it available through the Exchange.[59] However, the PPACA also provides that the Exchange must not exclude a health plan through the imposition of premium price controls.[60] The HHS will be effectively operating the Florida-based Exchange, at least initially, and making this determination. If a QHP is not certified, the product may still be offered outside the Exchange, but individuals purchasing that product would not be eligible for a premium subsidy, which are limited to coverage purchased through the Exchange.

Florida law requires that for individual and small group policies, health insurers must file rates for approval with the OIR. Rates for large group policies are not subject to filing or approval by the OIR. [61]

Rate filings must be submitted at least 30 days prior to use, and the filing is deemed approved unless the OIR disapproves the filing within 30 days, unless extended up to an additional 15 days. In practice, insurers may waive the deemer provision. The OIR must disapprove the rate filing if the policy provides benefits that are unreasonable in relation to the premium charged, based on specified factors, or contains provisions that apply rating practices that result in unfair discrimination.[62] (Also see Florida law under *Medical Loss Ratio* below.) Rate filings are prohibited from applying specified rating practices and the Financial Services Commission has adopted rules specifying procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates.[63] Health insurers subject to rate filing requirements must make an annual rate fling or file a certification that benefits are reasonable in relation to premiums currently charged. Similar requirements apply to rate filings for HMOs.[64]

[56] http://companyprofiles.healthcare.gov/
[57] 45 C.F.R. s. 154.225(a)
[58] 45 C.F.R. s. 154.230(c)
[59] PPACA s. 1311(e) (42 U.S.C. s. 18031(e)(2)); 45 C.F.R. s. 155.1020
[60] PPACA s. 1311(e)(1) (42 U.S.C. s. 18031(e)(1)); 45 C.F.R. s. 155.1000(c)(2)(ii)
[61] SS. 627.410(6)(a) and (c), F.S
[62] SS. 627.411(1)(f) and (2), F.S.
[63] SS. 627.410(6)(b) and (d); 69O-149, F.A.C.
[64] S. 641.31(3); 69O-194.054, F.A.C.

Medical Loss Ratio; Payment of Rebates- Effective for plan years beginning 1/1/2011, the PPACA requires health insurers to report to the HHS information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio or MLR). Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets. Grandfathered health plans are not exempt from this requirement.

Florida law requires as a condition of prior approval of rates by the OIR, that the projected minimum loss ratio for small group and individual policies is 65 percent.[65] Rebates are not required if the MLR is not met. The calculation of MLR is not consistent with federal regulations.

The most significant insurance requirements of the PPACA apply to health insurance policies that have plan years beginning on or after January 1, 2014, as follows:

Guaranteed Availability of Coverage[66] – The PPACA requires health insurers to accept every individual and every employer that applies for coverage, commonly referred to as offering coverage on a guaranteed issue basis. However, insurers may limit enrollment to open or special enrollment periods, as specified by HHS rules. Insurers that offer coverage through a network plan may limit enrollment based on network adequacy, under certain conditions. Insurers may deny coverage if it has demonstrated to the applicable state authority, if required, that it does not have the financial reserves necessary to underwrite additional coverage and is applying this uniformly to all employers and individuals consistent with applicable state law and without regard to the claims experience or health status of any individual or employer.

As required by HHS rules,[67] insurers must have open enrollment periods the same as required for coverage offered through a Health Insurance Exchange. For individual coverage, the initial open enrollment period is from October 1, 2013, through March 31, 2014. For each year thereafter, the open enrollment period is October 15 through December 7. In addition, for individuals with non-calendar-year policies, a one-time limited open enrollment period must be provided for 30 days prior to the date the policy year ends in 2014, (the intention being to transition all individuals to calendar-year policies). Insurers must provide special enrollment periods for individuals for many situations, such as losing minimum essential coverage, losing group coverage, gaining a dependent through birth or marriage, among others. For group coverage, insurers must provide year-round open enrolment, except for small employers who are unable to meet the insurer's minimum contribution or minimum participation requirements, pursuant to state law, for which the open enrollment period may be limited to November 15 through December 15.

Grandfathered health plans are exempt from these requirements.

Florida law does not require guaranteed issue of coverage to all individuals, but it provides for guaranteed availability of coverage for individuals who lose group coverage. These provisions of Florida law were enacted in 1997 to conform to federal HIPPA requirements.[68] The primary

[65] S. 627.411(3)(a), F.S.
[66] PPACA s. 1201; PHSA s. 2702 (42 U.S.C. s. 300gg-1)
[67] Final rules published in 78 F.R. 13406 (Feb. 27, 2013) and 77 F.R. 18310 (March 27, 2012)
[68] Chapter 97-179, L.O.F.

requirement is that the former group insurer must offer an individual conversion policy, the premium for which cannot exceed 200 percent of the standard risk rate.[69] Similar requirements to offer a conversion policy apply to HMOs.[70] For persons who lose group coverage but are not eligible for a conversion policy, such as an individual who was covered under a self-insured plan, a health insurer that offers individual coverage must offer that person their two most popular individual products, by premium volume in the state.[71]

Under Florida law, a group health insurer is not required to issue a conversion policy to a person who is covered for similar benefits by another insurance policy or contract, or is eligible for similar benefits, whether or not actually provided coverage. A conversion policy may provide that the insurer may refuse to renew the policy for these reasons if the benefits from such other sources, together with the benefits of the conversion policy, would result in overinsurance according to the insurer's standards on file with the OIR. The law specifies other reasons for which a group insurer may refuse to renew a conversion policy, including other reasons approved by the OIR.

Under Florida law, an HMO is not required to offer a conversion contract to a person who is covered for similar benefits by another insurance policy or contract or is eligible for similar benefits, whether or not covered. The HMO conversion contract must contain a cancellation or nonrenewability clause providing that the HMO may refuse to renew the contract, but cancellation or nonrenewal must be limited to one or more specified reasons. The specified reasons do not include the person (subscriber) being eligible for similar benefits under other coverage.

Florida law also requires small group carriers to offer coverage on a guaranteed issue basis to all small employers, including sole proprietors.[72] For sole proprietors, the offer of coverage may be limited to a one-month open enrollment period in August. Small group carriers must offer a standard and basic policy containing specified minimum benefits.

Non-Discrimination Based on Health Status[73]**-** The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the HHS. Grandfathered health plans are exempt from these requirements.

Florida law, for individual policies, does not prohibit insurers from medically underwriting or denying coverage based on health-related factors, other than for persons who lose group coverage as summarized above. Small group carriers are prohibited from establishing rules for

[69] S. 627.6675, F.S.
[70] S. 641.3922, F.S.
[71] S. 627.6487, F.S.
[72] S. 627.6699, F.S.
[73] PPACA s. 1201; PHSA s. 2705 (42 U.S.C. s. 300gg-4)

eligibility based on health-status related factors.[74] For all group policies, rules for eligibility of employees may not be based on health-status related factors.[75]

Pre-Existing Condition Exclusions[76] – The PPACA prohibits health insurance policies from excluding coverage for any pre-existing condition. Individual (but not group) grandfathered health plans are exempt from this requirement.

Florida law prohibits individual health policies from excluding preexisting conditions for more than 24 months and may relate to conditions that manifested themselves during the 24-month period.[77] Individual health policies may exclude coverage for named or specific conditions without any time limit.[78]

Florida law prohibits group policies from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the 6-month period prior to coverage. Prior creditable coverage reduces the exclusion period.[79]

Essential Health Benefits and Levels of Coverage[80] – The PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

States were provided the opportunity to select a benchmark plan among various options that reflected the scope of services offered by a "typical employer plan." Florida did not make a selection, resulting in a default to a benchmark plan being selected, which is the small group plan with the largest enrollment in the state. A benchmark plan must be supplemented, if necessary, to cover all categories of essential benefits. States may mandate additional benefits but must defray the expenses of enrollees for the additional cost of these benefits.

[74] S. 627.6699, F.S.
[75] S. 627.65625, F.S.
[76] PPACA s. 1201; PHSA s. 2704 (42 U.S.C. 300gg-3)
[77] S. 627.6045, F.S.
[78] S. 627.607(2), F.S.
[79] S. 627.6561, F.S.
[80] PPACA s. 1302; PHSA s. 2707 (42 U.S.C. 300gg-6)

Insurers must offer the following levels of coverage in the individual and small group markets:

- Bronze level -- Provides benefits that are actuarially equivalent to 60 percent of the full actuarial value of benefits under the plan.
- Silver level -- Provides benefits that are actuarially equivalent to 70 percent of the full actuarial value of benefits under the plan.
- Gold level -- Provides benefits that are actuarially equivalent to 80 percent of the full actuarial value of benefits under the plan.
- Platinum level -- Provides benefits that are actuarially equivalent to 90 percent of the full actuarial value of benefits under the plan.
- Catastrophic coverage -- Limited to adults under age 30 or individuals who are exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption.

Grandfathered health plans are exempt from these requirements.

Florida law mandates coverage of numerous benefits, services, and providers of services. However, there is no mandated essential health benefit plan.

Rating and Underwriting Standards[81] –The PPACA requires that premiums for individual and small group policies may vary only by:

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

The claims experience of all individual policies and all small group policies, respectively, must be pooled together for rating purposes. States may require that individual and small group policies be pooled together.

Grandfathered health plans are exempt from these requirements.

Florida law does not specify factors that may be used for individual coverage, but pursuant to rules, insurers are allowed to use age, gender, family composition, area by county, and tobacco usage. Carriers may also surcharge or "rate up" based on health status. The claims experience of all policies providing similar benefits must be pooled together for rating purposes.

For small group coverage, Florida law requires the use of rating factors based on gender, age, family composition, tobacco usage, and geographic area. In addition, premium adjustments of plus or minus 15 percent of the approved rate are allowed for claims experience, health status, and duration of coverage. The claims experience of all policies providing similar benefits must

[81] PPACA s. 1201; PHSA s. 2701 (42 U.S.C. 300gg)

be pooled together, except that policies covering fewer than two employees may be separately pooled.

Coverage for Clinical Trial Participants[82] **–** The PPACA prohibits an individual or small group plan from denying a qualified individual from participating in an approved clinical trial; denying or limiting conditions on the coverage of routine patient costs for items and services provided in connection with the trial; and discriminating against qualified individuals on the basis of such participation. Grandfathered health plans are exempt from this requirement.

Temporary Reinsurance Program for the Individual Market[83] – The PPACA requires each state or the HHS to establish a temporary reinsurance program for plan years beginning in 2014-2016. The goal of the program is to stabilize premiums by partially offsetting claims for high-cost individuals in nongrandfathered plans for the first three years of the exchange operations.

Insurers and third-party administrators of self-insured plans must make payments to the reinsurance entity. Nongrandfathered, individual market insurers that cover high-risk individuals will receive payments from the entity if they cover high-risk enrollees in the individual market.

States may: 1) operate its own program and collect from the fully insured market and allow the HHS to collect contributions from the self-insured market; or 2) operate its own program including the payment function, and defer all collection duties to the HHS. If the HHS operates a state's reinsurance program, the HHS will collect all contributions and perform payment functions. Florida is not operating a temporary reinsurance program

Temporary Risk Corridors for Plans in the Individual and Small Group Market[84] – The PPACA requires the HHS to establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare Prescription Drug Plans. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103 percent. Plans must make payments if that ratio is below 97 percent.

Risk Adjustment[85] – The PPACA requires each state to assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state.

The HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.

[82] PPACA s. 1201; PHSA s. 2709 (42 U.S.C. 300gg-8
[83] PPACA s. 1341 (42 U.S.C. s. 18061)
[84] PPACA s. 1342 (42 U.S.C. s. 18062)
[85] PPACA s. 1343 (42 U.S.C. s. 18063)

Premium Impact of the PPACA

The most significant requirements of the PPACA become effective for plan years beginning on January 1, 2014, which are the requirements that are expected to have the biggest impact on average premiums. The primary drivers of increased average premiums due to the PPACA are:

- Guaranteed issue and related requirements – The requirement of the PPACA for insurers to accept every individual and employer who applies for coverage will allow persons with health conditions requiring expensive medical care to obtain coverage who are currently unable to obtain coverage, due to their health status, or who currently pay a premium surcharge due to an identified health condition. This premium impact is affected by the related PPACA requirements that insurers may not exclude coverage for any preexisting condition and may not use health status as a factor in establishing rates. To some extent the upward impact will be reduced due to the individual coverage mandate, which will attract healthier individuals who prefer to obtain coverage rather than pay the fee (tax). The upward impact on average premiums will also be partially offset by attracting healthier persons due to the premium subsidies for eligible persons, based on income level, for coverage through the Exchange.
- Actuarial Value – The PPACA requires insurers in the individual and small group market to offer plans meeting required actuarial levels, the lowest of which (other than the catastrophic plan for eligible individuals) is the bronze level plan, which must provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of benefits under the plan. This requirement limits the amount of the deductible, co-payment, and other out-of-pocket expenses that can be imposed on the policyholder. This will have the biggest impact on policies which currently have large deductibles and other large out-of-pocket expense provisions.
- Essential Health Benefits – All policies in the individual and small group market must cover essential health benefits which will impact premiums due to adding benefits for maternity care, prescriptions drugs, behavioral health, habilitative services, pediatric dental, and other essential health benefits that may not be covered or fully covered under current policies. Certain other benefits were required for policy years beginning after September 23, 2010, for which premiums should already reflect the impact.
- Fees and Assessments – The PPACA imposes a health insurance industry fee, a temporary reinsurance assessment, a fee for covering operation of the Exchange, and a fee for funding patient-centered outcomes research, that will directly impact premiums, as well as taxes on certain medical devices likely to be passed on to patients and insurers. Offsetting the temporary reinsurance assessment are reinsurance credits that an insurer may receive for covering high-risk individuals.

Age and Gender – In addition to requirements that affect average premiums are the rating reforms that affect a particular individual's premium due to age and gender. By limiting age factors for adults to a maximum ratio of 3 to 1, younger adults will have higher premiums and older adults will have lower premiums, due solely to this factor. The requirement that insurers may not use gender as a rating factor is expected to result in higher premiums for younger males and older women, and lower premiums for older men and younger females, due solely to this requirement. Thus, the most significant upward impact on rates is expected for young males and the most significant downward impact is expected for older males.

Role of Navigators and Brief Background on Exchanges and Qualified Health Plans

Beginning on October 1, 2013, individuals and small businesses will be able to purchase private health insurance through state-based marketplaces called Affordable Insurance Exchanges (Exchanges). Exchanges must certify qualified health plans (QHPs) offered by insurers through the Exchange, which coverage is effective beginning on January 1, 2014. The HHS must establish and operate Exchanges within states that do not elect to establish an Exchange, which is the current status for Florida.

The PPACA directs Exchanges to award grants to "navigators" that will conduct public education activities to raise awareness of the availability of QHPs, distribute fair and impartial information concerning enrollment in QHPs, including the availability of premium tax credits and cost-sharing reductions, facilitate enrollment in QHPs, and provide referrals to any applicable office of consumer or health insurance ombudsmen for any enrollee with a grievance, complaint, or question about their health plan or coverage.[86] According to the HHS, navigators will not make eligibility determinations and will not select QHPs for consumers or enroll applicants into QHPs, but will help consumers through the eligibility and enrollment process.[87]

On April 9, 2013, the HHS announced that it will award up to $54 million in grants to individuals and entities to act as navigators in the 33 states that have federally facilitated Exchanges, of which up to $5.85 million will be awarded in Florida.[88] The anticipated award date is August 15, 2013, for up to a 12-month period of performance.

The Exchange must develop standards for navigators designed to prevent any conflicts of interest and training standards to assure expertise in the needs of underserved populations, eligibility and enrollment rules, the range of QHP options, and privacy and security standards.[89] Proposed HHS rules require navigators and assistance personnel in navigator entities to obtain certification from an Exchange and to complete HHS-approved training, described as 30 hours, and receive a passing score on HHS-approved examinations.[90]

The Exchange must award navigator grants to at least one community and consumer-focused non-profit group and at least one other specified category including, among others, trade industry, and professional associations; chambers of commerce; unions; licensed agents and brokers; and other public or private entities or individuals that meet specified requirements. However, a navigator may not be a health insurer, a subsidiary of a health insurer, or an association that has members of, or lobbies on behalf of the insurance industry. Also, a navigator may not receive any direct or indirect consideration from any health insurer in connection with the enrollment of individuals or employees in a QHP or non-QHP.[91] This effectively prohibits

[86] PPACA s. 1311(i) (42 U.S.C. s. 18031(i); 45 C.F.R. s. 155.210
[87] HHS proposed rules, *[PPACA];Exchange Functions; Standards for Navigators and Non-Navigators Assistance Personnel*, 78 C.F.R. 66, p. 20581, at 20583
[88] http://www.grants.gov/search/announce.do;jsessionid=rMGQRmsRLLQ6LvXJVQnyMcL3L1QPZQcKh6wsxfHzmGCG9N19jBMF!-488397891
[89] 45 C.F.R. s. 155.210
[90] Proposed rule 45 C.F.R. s. 155.215; 78 C.F.R. 66, p. 20595, summarized on p. 20588
[91] Id

health insurance agents from serving as navigators if they are receiving commissions from insurers for enrollment, but health agents are allowed to enroll individuals in QHPs through an Exchange.[92]

A navigator must meet any licensing, certification, or other standards established by a state.[93] But, due to the PPACA's preemption provision, any such standards may not prevent the application of a provision of the PPACA, as clarified by proposed HHS rules.[94]

Florida Comprehensive Health Care Association (FCHA)

The FCHA is Florida's high-risk pool for individuals who are unable to obtain health insurance, due to their health status. The FCHA, formerly named the State Comprehensive Health Association, was created in 1982.[95] About 7,500 individuals were insured with the FCHA in 1991, but due to increasing losses, legislation that year closed the FCHA to new enrollment, but allowed existing insureds to renew coverage. At the end of 2012, there were 176 individuals insured with the FCHA.

The FCHA is organized as a not-for-profit entity. All health insurers, as a condition of doing business, must be members of the association. The FCHA is governed by a three-member board of directors appointed by the Chief Financial Officer and regulatory oversight is provided by the OIR.

The FCHA is funded through a combination of premiums paid by FCHA policyholders and an assessment on all health insurers and HMOs in the state to cover FCHA operating losses. The annual assessment on health insurers is based on the earned premiums of the insurers.[96] FCHA policyholder premiums are based on commercial standard risk rates as determined by the OIR and are set at 200 percent, 225 percent and 250 percent of the individual market standard risk rate, depending on the level of risk.[97]

For 2012, premiums paid by FCHA members were $1,252,788 compared to claims of $1,700,473. The operating loss of the association and the related insurance industry assessment for 2012 was $810,539. The operating loss and the resulting insurance industry assessment for 2011 was $2,245,828.[98]

Florida Health Insurance Plan

In 2004, the Legislature created the Florida Health Insurance Plan (Plan).[99] The Plan was intended to replace the FCHA as the State's high risk insurance pool. The Board of the Plan may

[92] 45 C.F.R. s. 155.220(a)
[93] 45 C.F.R. s. 155.210(c)(1)(iii)
[94] Proposed rule 45 C.F.R. s. 155.210(c)(1)(iii), 78 C.F.R. 66, p. 20595
[95] SS. 627.648-627.6498, F.S. is cited as Florida Comprehensive Health Association Act.
[96] S. 627.6492, F.S.
[97] S. 627.6498, F.S.
[98] Florida Comprehensive Health Association data, on file in committee.
[99] Ch. 2004-297, s. 21, L.O.F.

not implement the Plan until funds are appropriated for startup costs and any projected deficits.[100] These funds have never been appropriated and so the Plan is not in operation.

III. Effect of Proposed Changes:

State Law Recognition of the PPACA's Limited Preemption of State Law (Sections 1 and 14)

The bill creates a statute in the Florida Insurance Code[101] providing that a provision of the Code or rule adopted pursuant to the Code applies unless such provision or rule prevents the application of a provision of the PPACA, defined as including regulations adopted pursuant to the PPACA. This is substantially the same preemption provision that is included in the PPACA. This provision would allow the OIR to rely on a state law, rather than, or in addition to, federal law, to make a determination that a provision of the Florida Insurance Code is preempted and not legally enforceable.

Authorization for the OIR and the DFS to Assist the HHS in Enforcing the PPACA (Revision to Collaborative Arrangement) (Section 2)

The bill statutorily authorizes the OIR, when reviewing forms filed by health insurers or HMOs (insurers) and when performing market conduct examinations or investigations of such insurers, for compliance with state law, to also review or examine for compliance with the PPACA. If the OIR determines that a form or the insurer's operations do not comply with the PPACA, the OIR must notify the insurer of such determination. If the form ultimately used by the insurer does not comply with the PPACA, or the insurer does not take action after an examination or investigation to comply with the PPACA, the OIR may report such potential violation to the HHS.

This statutory authorization differs from the collaborative arrangement described in the March 12, 2013, letter from the HHS to the Florida Insurance Commissioner in the following respects:

- Authorizes, rather than requires, the OIR to take certain actions related to enforcement of the PPACA;
- Does not authorize the OIR to review rates for compliance with the PPACA (and makes no reference to the OIR's authority to review rates for compliance with state law, which the bill substantially revises).
- Expressly requires the OIR to notify the insurer of its determination of a violation of the PPACA and does not refer to the OIR being "unable to obtain voluntary compliance."
- Authorizes the OIR to review for compliance with the PPACA, rather than "all federal laws and regulations."
- Authorizes the Division of Consumer Services to take certain actions related to consumer complaints related to the PPACA, as described below.

The bill authorizes the Division of Consumer Services to respond to complaints by consumers relating to requirements of the PPACA, as authorized under s. 20.121(2)(h), F.S., which provides

[100] S. 627.64872(6), F.S.
[101] As specified in s. 624.01, F.S., the Florida Insurance Code consists of chapters 624-632, 634, 635, 636, 641, 648, and 651, F.S.

the division's current statutory responsibilities to prepare and disseminate information to consumers as it deem appropriate, provide direct assistance and advocacy to consumers, and require insurers to respond, in writing, to a complaint. The bill further authorizes the division to report apparent or potential violations to the OIR and to the HHS.

As expressly provided, a determination made by the OIR or the DFS regarding an insurer's compliance with the PPACA would not be a determination that affects the insurer's substantial interests for purposes of chapter 120, F.S., and, therefore, would not provide the insurer with a right to an administrative hearing. Given that the OIR's authorized actions after a determination are limited to notifying the HHS, and that the DFS's authorized actions are current consumer assistance functions and notifying the HHS, it is questionable whether a right to an administrative hearing would be triggered in the absence of this provision. Any subsequent imposition of civil monetary penalties by the HHS against an insurer is subject to federal administrative hearing rights.[102]

Temporary Suspension of Required Approval of Rates for Nongrandfathered Health Plans (Sections 15, 16 and 24)

The bill temporarily suspends the requirement that the OIR approve rates for health insurers and HMOs (insurers) filed with the OIR for nongrandfathered health plans for plan years 2014 and 2015. Insurers would still be required to file rates and rate changes for nongrandfathered health plans with the OIR prior to use, as required by s. 627.410(6)(a), F.S., but such rates could be used without OIR approval and the rate filing and rates would be exempt from:

- Section 627.410(2) and (6)(c), F.S., which specify procedures for OIR approval or disapproval;
- Section 627.410(6)(b), F.S., which authorizes the Financial Services Commission to adopt rules for procedures to be used in ascertaining the reasonableness of benefit in relation to rates;
- Section 627.410(6)(d), F.S., which prohibits specified rating practices;
- Section 627.410(7), F.S., which requires an annual rate filing or an actuarial certification that benefits are reasonable in relation to rates;
- Provisions of s. 627.411, F.S., which apply to rates, rating practices, or the relationship of benefits to the premium charged. This section provides grounds for the OIR to disapprove both forms and rates, so the exemption would be limited to those provisions related to rates.

These rating law changes are repealed on March 1, 2015, and the law will revert to the current requirement for insurers to file rates for approval with the OIR for nongrandfathered plans for plan years 2016 and thereafter.

Insurers will remain subject to the requirements of the PPACA to file rate changes with the CMS (HHS) for nongrandfathered health plans, subject to CMS review and determination of whether the rate increase is unreasonable. The CMS would apparently no longer consider Florida as having an effective rate review program and would not rely on the OIR to make this

[102] 45 C.F.R. Part 150

determination. For the actions that the CMS (HHS) may take with respect to a rate increase it determines is unreasonable, see, *Review of Insurer Premium Increases*, above, and for required rebates see, *Medical Loss Ratio; Payment of Rebates*, above.

Grandfathered health plans are not subject to the PPACA rate filing requirements and would remain subject to the current Florida law requirements for filing rates for approval with the OIR and all other current requirements for health insurance rates.

Required Notice to Policyholders of Impact of the PPACA on Premiums (Section 15)

The bill requires that insurers and HMOs (insurers) provide a notice to policyholders of individual and small group nongrandfathered plans that describes or illustrates the estimated impact of the PPACA on monthly premiums. This notice will be required one time, when the policy is issued or renewed on or after January 1, 2014. The notice must also be submitted to the OIR for informational purposes by September 1, 2013. The OIR, in consultation with the DFS, must develop a summary of the estimated impact of the PPACA on monthly premiums as contained in the notices. The summary must be available on the OIR and DFS websites by October 1, 2013. The notice is also required to be included in the insurer's rate filing for the policy (which is not subject to approval by the OIR).

The notice must be in a format established by rule by the Financial Services Commission (commission). The format may allow for specified variations from the bill's specific requirements (below) in order to provide a more accurate and meaningful disclosure, as determined by the commission. The information in the notice must be based on the statewide average premium for the bronze, silver, gold, or platinum level plan, whichever is applicable to the policy, and provide an estimate of specified effects of the following PPACA requirements:

- The dollar amount of the premium attributable to the impact of guaranteed issuance of coverage;
- The dollar amount of the premium attributable to fees, taxes, and assessments;
- For individual policies, the dollar amount of the premium increase or decrease attributable to the combined impact of the age and gender rating requirements of the PPACA, shown for specified age brackets for males and females;
- The dollar amount attributable to the requirement to cover essential health benefits and to meet a required actuarial value, as compared to the statewide average premium for the policy of that insurer that has the highest enrollment in the individual or small group market, whichever is applicable.

Definitions of Grandfathered Health Plan and Nongrandfathered Health Plan (Section 14)

The bill defines "grandfathered health plan" as having the same meaning as that term is defined for purposes of the PPACA, including the conditions of HHS rules for maintaining status as a grandfathered health plan. (See Present Situation.)

The bill defines "nongrandfathered health plan" as a health insurance policy or HMO contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6561(5)(b)-(e), F.S., which include hospital indemnity or other fixed indemnity

insurance, accident-only coverage, specified disease coverage, disability income insurance, limited scope dental or vision coverage, Medicare supplement coverage, long-term care or nursing home coverage, and other specified limited benefit coverages. These are substantially the same coverages that are excluded from the federal definition of "health insurance coverage" subject to the requirements of the PPACA.[103]

Preserving Status of Grandfathered Health Plans (Sections 15, 17, and 21)

The bill makes changes that would allow or require insurers to take certain actions that would preserve the status of grandfathered health plans.

If a policy form covers both grandfathered health plans and nongrandfathered health plans, the bill allows an insurer to non-renew coverage only for all of the nongrandfathered health plans, subject to the requirement to provide at least 90 days notice and to offer each of those policyholders the option to purchase any other individual health insurance coverage offered by the insurer. The federal law[104] requiring guaranteed renewability of coverage, on which the Florida law was modeled as part of the 1997 act conforming to HIPPA, does not recognize this exception and this amendment to the Florida law may be preempted. However, it may also be argued that under federal law, the specific provisions of the PPACA requiring preservation of existing coverage for grandfathered health plans allow for this exception.

The bill allows an exception to the current law that prohibits an insurer from filing for approval a new policy form providing benefits similar to a policy form that the insurer discontinues. The exception would be for a policy form that is discontinued because it does not comply with the PPACA. An insurer that discontinues a form that does not comply with the PPACA would not be prohibited by Florida law from filing or issuing a new policy form.

The bill requires that the claims experience for grandfathered health plans be separated from nongrandfathered health plans for rating purposes, which is also required by the PPACA.

Definitions of "Small Employer" for Grandfathered and Nongrandfathered Health Plans (Section 23)

The bill provides two different definitions of "small employer" – one for grandfathered plans, which is the current law definition, and one for nongrandfathered plans, which is the same as the federal definition used for the PPACA.

The effect of this change, for nongrandfathered plans only, is to apply state law requirements for small group coverage to small employers, as defined under the PPACA, and no longer apply any state law for small group coverage to an employer who is not a small employer under the federal definition. That is, insurers who issue nongrandfathered coverage to sole proprietors, or to employers who have more than 50 employees but are considered a small employer under current Florida law (due to hours worked per week), or to any other employer that is not a small employer under federal law, would no longer be subject to any requirement of Florida law that

[103] See, definitions of "health insurance coverage", "individual health insurance coverage", and "excepted benefits" in 42 U.S.C. s. 300gg-91.
[104] 42 U.S.C. s. 300gg-2(c)(1)

applies to small group coverage. These employers would either be considered individual policyholders or large group policyholders under Florida law, as they are under the PPACA, and be subject to Florida laws that apply to individual coverage or large group coverage.

Even though Florida law and the PPACA will continue to have different requirements for individual, small group, and large group coverage, and determinations must be made as to which Florida laws are preempted, the additional complication of differing definitions of small employer will be eliminated for nongrandfathered policies. This will enable insurers to more easily comply with requirements of the PPACA that are different for individual, small group, and large group policies, such as pooling of claims experience and MLR refunds, for nongrandfathered policies.

Grandfathered policies will continue to be subject to different definitions of small employer under state and federal law. Grandfathered policies are exempt from many of the PPACA insurance requirements, so current Florida small group coverage requirements would continue to apply to the same small employers, as currently defined, including those that are not small employers under federal law. However, some PPACA provisions apply to grandfathered policies, such as MLR refunds, and insurers will be required to use the federal definition of small employer for those provisions.

Use of Gender as a Rating Factor for Small Group Policies (Section 23)

The bill specifies that a small employer carrier is not required to use gender as a rating factor for nongrandfathered plans, which is prohibited under the PPACA. The bill resolves this potential conflict in state law that may prevent application of the PPACA's rating requirements.

Required State Registration of Navigators (Sections 3-13)

Individuals acting or offering to act as a navigator will be required to be registered with the DFS, beginning August 1, 2013. The express purpose of registration is to authorize an individual to facilitate the selection of a QHP through an Exchange by providing fair, accurate, and impartial information regarding QHPs and the availability of tax credits and cost sharing reductions, and to prohibit specified activities or conduct.

For purposes of the registration requirement, a "navigator" is defined as an individual authorized by an Exchange to serve as a navigator, or who works on behalf of an entity authorized by an Exchange to serve as a navigator, who facilitates selection of a QHP through the Exchange and performs any other duties of a navigator as specified by rules adopted by the HHS.

To be registered, an individual must certify that he or she has completed all training for a navigator required by the federal government or the Exchange and must submit fingerprints for a criminal background check. The applicant must pay a $50 application fee plus a $50.30 fingerprint processing fee ($100.30 total). There is no requirement or fee for renewal of the registration.

An applicant who has committed a felony involving money laundering, fraud, or embezzlement or a felony directly related to the financial services business is permanently barred from

registration. Certain other crimes would disqualify an applicant for specified periods, the lowest level being any misdemeanor directly related to the financial services business which would disqualify an applicant for 7 years. ("Financial services business" is defined as any financial activity regulated by the DFS, the OIR, or the Office of Financial Regulation.) These same crimes and disqualifying periods currently apply to insurance agent applicants, pursuant to s. 626.207, F.S.

A navigator will be prohibited from soliciting, negotiating, or selling health insurance unless licensed as a health insurance agent or customer representative, and even if licensed, would be prohibited from such activities while performing duties as a navigator. A navigator will also be prohibited from:

- Recommending the purchase of a particular health plan or represent that one health plan is preferable over any other;
- Recommending or assisting with the cancellation of insurance coverage purchased outside the exchange;
- Receiving compensation or anything of value from an insurer, health plan, business, or consumer in connection with performing activities as a navigator, other than from the Exchange or an entity or individual who has received a navigator grant under the PPACA.

The grounds for suspension or revocation of a navigator's registration include violation of any provisions in the part of chapter 626, F.S., created by this bill, or any other applicable provision of the chapter. Certain grounds for revocation or suspension are the same that currently apply to an individual who has an insurance agent license (as provided in ss. 626.611 and 626.621, F.S.), including:

- Violation of any lawful order or rule of the DFS;
- Lack of one or more of the required qualifications;
- Material misstatement, misrepresentation, or fraud in obtaining or attempting to obtain registration;
- Any cause for which issuance of the registration could have been refused had it then existed an been known to the DFS;
- Having been found guilty or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more;
- Failure to inform the DFS in writing within 30 days after pleading guilty or nolo contendere to any such crime;
- Knowingly aiding or assisting any person in violating a provision of the Insurance Code or any order or rule of the DFS, the OIR, or the Financial Services Commission;
- Failure to comply with any civil, criminal, or administrative action taken by the federal child support enforcement program.

The bill also authorizes the DFS to suspend or revoke a navigator's registration if the individual has been the subject of disciplinary or other adverse action by the federal government or an Exchange as a result of a violation of any provision of the PPACA.

The bill authorizes the DFS to impose an administrative fine in lieu of, or in addition to suspension or revocation, in an amount up to $500 or, if the DFS finds willful misconduct or a willful violation, up to $3,500. These are the same administrative fines that currently apply to insurance agents in s. 626.681, F.S.

Any person who acts as a navigator without registration is subject to an administrative penalty not to exceed $1,500.

The DFS will be authorized, pursuant to s. 120.569, F.S. to issue a cease and desist order or an immediate final order to cease and desist to any person who violates the section that specifies prohibited acts for a navigator and prohibits a person acting as a navigator without being registered. Any person who violates an order is subject to a penalty of up to $50,000 and suspension or revocation of registration. Substantially the same powers and penalties apply in current law with regard to persons who engage in unfair insurance trade practices or the unlawful transaction of insurance, pursuant to ss. 626.9581-626.9601, F.S.

The DFS will be authorized to adopt rules to implement the provisions of the new laws created for the registration of navigators.

Conversion Policies and Contracts (Sections 22 and 25)

The bill amends s.627.6675, F.S., to clarify that a group insurer is not required to renew a conversion policy if a person is covered for similar benefits by another insurance policy or contract or is eligible for similar benefits, whether or not actually provided coverage. The bill specifies that a nonrenewal for this reason is not required to be contained in the converted policy, but must be provided in writing to the policyholder at least 90 days before the policy renewal date.

The bill amends s. 641.3922, F.S., to allow an HMO to non-renew a conversion contract if a person is covered for similar benefits by another insurance policy or contract or is eligible for similar benefits, whether or not covered. (This is a reason for which the current law provides that the HMO is not required to issue the conversion contract.) The bill further provides that this reason for nonrenewal is not required to be contained in the conversion contract, but must be provided in writing to the subscriber at least 90 days before the contract renewal date.

Any individual, including anyone who has a conversion policy non-renewed, will be eligible under the PPACA for guaranteed issuance of coverage, effective January 1, 2014, regardless of health status, and without exclusion for any prexistsing condition.

Dissolution of the Florida Comprehensive Health Association (Sections 18 and 20)

The bill requires the dissolution of the Florida Comprehensive Health Association (FCHA). Coverage for each FCHA policyholder would be terminated on June 30, 2014, or on the date that health insurance coverage is effective with another insurer, whichever is earlier. The FCHA would be required to assist each policyholder in obtaining health insurance coverage, including identification of insurers and HMOs offering coverage and other specified information. The

FCHA would be required to provide a written notice to each policyholder by September 1, 2013, regarding termination of their coverage and information on how to obtain other coverage.

The bill specifies that by March 15, 2015, the FCHA must determine the final assessment to be collected from member insurers or, if surplus funds remain, the refund to be provided to insurers based on the same pro-rata formula. The bill specifies the actions the FCHA must take to dissolve the corporation by September 1, 2015, including transfer of all records to the DFS as custodian. According to representatives of the FHCA, typical responsibilities would include providing copies of claims records to policyholders. The FCHA would be required to transfer any remaining funds (such as proceeds from the sale of assets) to the Chief Financial Officer for deposit in the General Revenue Fund.

All of the statutes that relate solely to the operations of the FHCA would be repealed, effective October 1, 2015, which is one month later than the September. 1, 2015, date that the FCHA must be dissolved.

Repeal of the Florida Health Insurance Plan (Section 19)

The bill repeals the statute that establishes the Florida Health Insurance Plan, which has never been implemented.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Applicants for registration as a navigator will be required to pay a $50 application fee plus a fee for the actual cost of fingerprint processing, which is currently $50.30. There is no renewal fee.

B. Private Sector Impact:

It is unknown to what extent health insurance premiums for individual and small group nongrandfathered health plans will be any greater, or possibly even lower, due to deleting the requirement for insurers to obtain approval of rate changes by the OIR for such policies. Representatives of the OIR have expressed concerns that due to lack of

historical claims data, the OIR will not be able to effectively challenge an insurer's determination of the effect of the PPACA's requirements for guaranteed issue of coverage to all individuals and employers, to add coverage for essential health benefits, and increase benefits to required actuarial levels. But, it is unclear to what extent the OIR has the ability or resources to engage expert consultants or otherwise rely on actuarial studies to challenge the reasonableness of an insurer's assumptions or the quality of their data.

The impact of not requiring OIR approval of a rate change may be mitigated by the requirement of the PPACA that insurers file rate increases with the HHS, subject to an HHS determination as to whether a rate increase over 10 percent is unreasonable. The HHS does not have authority to disapprove the rate, but the HHS posts that determination on its website and requires the insurer to post that determination on its website for 3 years. Also, the authority for the Exchange to take unreasonable rate increases into consideration when determining whether to make the health plan available through the Exchange may lessen the impact of not requiring OIR approval. Finally, the PPACA requires insurers to provide refunds to policyholders if the minimum medical loss ratio is not met, which addresses an excessive rate after the fact, and may also prevent an insurer from making a rate change that it believes would require a refund.

Insurers issuing nongrandfathered health plans will be subject to the additional costs of preparing and providing the notice to policyholders of the impact of the PPACA on premiums.

To the extent that the bill allows insurers to take actions to preserve the status of grandfathered health plans, policyholders of such plans are less likely to be affected by the premium impact of changes that the PPACA requires for nongrandfathered plans.

Conforming the definition of "small employer" to the federal definition, for nongrandfathered plans, should reduce administrative burdens for insurers in administering their policies. This change should not have any significant impact on the coverage for any individual or employer, given that coverage and rating requirements of the PPACA will generally control over state law.

C. Government Sector Impact:

The OIR will be authorized to perform additional duties to assist the HHS in enforcing the PPACA and required, with the DFS, to prepare a report for their websites summarizing the notices from insurers of the impact of the PPACA on health insurance premiums. A representative from The OIR states that this can be done with existing resources.

For 2 years, the OIR will not be required to approve or disapprove rate filings for nongrandfathered health plans. Representatives from the OIR state that this will not reduce their need for current FTEs, given that major medical health insurance rate filings represent about 10 percent of the rate filings made, that rate filings will still be filed for approval for grandfathered health plans, and that the required filings (but not approval)

for nongrandfathered plans will still need to be analyzed for determining the impact of the PPACA on rates and to prepare for the time when rate approval is reenacted in 2 years.

The fiscal impact of authorizing the Division of Consumer Services to assist consumers with PPACA-related complaints has not been determined and depends, in part, on the extent to which the DFS would be assisting consumers with such complaints under its current law responsibilities [s. 20.121 (2)(h)].

The fiscal impact to the DFS due to the required licensure of navigators is estimated below,

Based on assumption of 3,000 applications first year, 480 applications annually thereafter:

	Fiscal Year 2013-2014	Fiscal Year 2014-2015
A. Revenues 1. Recurring: $50 Application filing fee x 3,000 = $150,000 1st year Thereafter, approximately $50 x 480 = $24,000	$150,000	$24,000
B. Expenditures 1. Recurring: 2 – Government Anaylst I (Pay Grade 22) [$36,468 (Base) + $15,061 (41.3% Benefits) + $1,800 (Expense Pkg) = $53,329 x 2]	$106,658	$106,658
2. Non-Recurring: Computer enhancements to accept applications & fingerprints and publish list of registrants. Temporary staffing to process first year volume of applications.	$70,000	
TOTAL EXPENSES	**$176,658**	**$106,658**

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Appropriations on April 18, 2013:
The committee substitute substantially revises the bill's requirements for navigators to be licensed by the DFS to, instead, require registration by the DFS. The changes include:

- Specification of revised prohibited acts and grounds for approval, suspension, or revocation of registration;
- Requiring that applicants complete all training required by the federal government or the Exchange, rather than a state 10-hour course;
- Additional powers for the DFS to fine or issues cease and desist orders for violations;
- Requiring applicants to pay the fingerprint processing fee;
- Revising the definition of "navigator".

The committee substitute revises the required notice that insurers must provide on the premium impact of the PPACA to authorize the Financial Services Commission, in adopting rules that specify the format of the notice, to allow for specified variations that provide a more accurate and meaningful estimate.

The committee substitute specifies that health insurers and HMOs are allowed to non-renew individual conversion policies if the individual is eligible for other similar coverage.

The committee substitute appropriates $106,658 in recurring funds and $70,000 in nonrecurring funds from the Insurance Regulatory Trust Fund and 2 FTEs to the Department of Financial Services for the 2013-2014 fiscal year to implement the provisions of this act related to the registration of navigators.

B. Amendments:

None.