By the Committee on Banking and Insurance

597-03435-13 20131842__

1 A bill to be entitled
2 An act relating to health insurance; creating s.
3 624.25, F.S.; providing that a provision of the
4 Florida Insurance Code applies unless it conflicts
5 with a provision of the Patient Protection and
6 Affordable Care Act (PPACA); creating s. 624.26, F.S.;
7 authorizing the Office of Insurance Regulation to
8 review forms and conduct market conduct examinations
9 for compliance with PPACA and to report potential
10 violations to the federal Department of Health and
11 Human Services; authorizing the Division of Consumer
12 Services of the Department of Financial Services to
13 respond to complaints related to PPACA and to report
14 violations to the office and the Department of Health
15 and Human Services; providing that certain
16 determinations by the office or the Department of
17 Financial Services are not subject to certain
18 challenges under ch. 120, F.S.; amending ss. 624.34,
19 626.022, and 626.207, F.S.; conforming provisions to
20 changes made by this act with respect to the licensure
21 of navigators under the Florida Insurance Code;
22 providing a directive to the Division of Law Revision
23 and Information; creating s. 626.995, F.S.; providing
24 for the licensure of navigators; providing
25 definitions; providing license requirements and
26 qualifications; specifying licensure conduct;
27 providing for disciplinary actions; providing for the
28 discontinuance of the license; prohibiting concurrent
29 licensure as an insurance agent; authorizing the

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30 Department of Financial Services to adopt rules;
31 amending s. 627.402, F.S.; providing definitions for
32 “grandfathered health plan,” “nongrandfathered health
33 plan,” and “PPACA”; amending s. 627.410, F.S.;
34 providing an exception to the prohibition against an
35 insurer issuing a new policy form after discontinuing
36 the availability of a similar policy form when the
37 form does not comply with PPACA; requiring the
38 experience of grandfathered health plans and
39 nongrandfathered health plans to be separated;
40 providing that nongrandfathered health plans are not
41 subject to rate review or approval by the office;
42 specifying that such rates for such health plans must
43 be filed with the office and are exempt from other
44 specified rate requirements; requiring insurers and
45 health maintenance organizations issuing such health
46 plans to include a notice of the estimated impact of
47 PPACA on monthly premiums with the first issuance or
48 renewal of the policy; requiring the Financial
49 Services Commission to adopt the notice format by
50 rule; requiring the notice to be filed with the office
51 for informational purposes; providing for the
52 calculation of the estimated premium impact, which
53 must be included in the notice; requiring the office,
54 in consultation with the department, to develop a
55 summary of the impact to be made available on their
56 respective websites; providing for future repeal;
57 amending s. 627.411, F.S.; providing that grounds for
58 disapproval of rates do not apply to nongrandfathered

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59 health plans; providing for future repeal of this
60 provision; amending s. 627.6425, F.S.; allowing an
61 insurer to nonrenew coverage only for all
62 nongrandfathered health plans under certain
63 conditions; amending s. 627.6484, F.S.; providing that
64 coverage for policyholders of the Florida
65 Comprehensive Health Association terminates on a
66 specified date; requiring the association to provide
67 specified assistance to policyholders in obtaining
68 other health insurance coverage; requiring the
69 association to notify policyholders of termination of
70 coverage and information on how to obtain other
71 coverage; requiring the association to determine the
72 amount of a final assessment or to refund any surplus
73 funds to member insurers, and to otherwise complete
74 program responsibilities; repealing s. 627.64872,
75 related to the Florida Health Insurance Plan;
76 providing for the future repeal of ss. 627.648,
77 627.6482, 627.6484, 627.6486, 627.6488, 627.6489,
78 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and
79 627.6499, F.S., relating to the Florida Comprehensive
80 Health Association; amending s. 627.6571, F.S.;
81 allowing an insurer to nonrenew coverage only for all
82 nongrandfathered health plans under certain
83 conditions; amending s. 627.6699, F.S.; adding and
84 revising definitions used in the Employee Health Care
85 Access Act; providing that a small employer carrier is
86 not required to use gender as a rating factor for a
87 nongrandfathered health plan; requiring carriers to

88 separate the experience of grandfathered health plans
89 and nongrandfathered health plans for determining
90 rates; amending s. 641.31, F.S.; providing that
91 nongrandfathered health plans are not subject to rate
92 review or approval by the office; providing for future
93 repeal of this provision; providing effective dates.
94
95 Be It Enacted by the Legislature of the State of Florida:
96
97 Section 1. Section 624.25, Florida Statutes, is created to
98 read:
99 624.25 Patient Protection and Affordable Care Act.—A
100 provision of the Florida Insurance Code, or rule adopted
101 pursuant to the code, applies unless such provision or rule
102 prevents the application of a provision of PPACA. As used in
103 this section, the term "PPACA" has the same meaning as provided
104 in s. 627.402.
105 Section 2. Section 624.26, Florida Statutes, is created to
106 read:
107 624.26 Collaborative arrangement with the Department of
108 Health and Human Services.—
109 (1) As used in this section, the term "PPACA" has the same
110 meaning as provided in s. 627.402.
111 (2) When reviewing forms filed by health insurers or health
112 maintenance organizations pursuant to s. 627.410 or s. 641.31(3)
113 for compliance with state law, the office may also review such
114 forms for compliance with PPACA. If the office determines that a
115 form does not comply with PPACA, the office shall inform the
116 insurer or organization of the reason for noncompliance. If the

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117 office determines that a form ultimately used by an insurer or
118 organization does not comply with PPACA, the office may report
119 such potential violation to the federal Department of Health and
120 Human Services. The review of forms by the office under this
121 subsection does not include review of the rates, rating
122 practices, or the relationship of benefits to the rates.
123 (3) When performing market conduct examinations or
124 investigations of health insurers or health maintenance
125 organizations as authorized under s. 624.307, s. 624.3161, or s.
126 641.3905 for compliance with state law, the office may include
127 compliance with PPACA within the scope of such examination or
128 investigation. If the office determines that an insurer's or
129 organization's operations do not comply with PPACA, the office
130 shall inform the insurer or organization of the reason for such
131 determination. If the insurer or organization does not take
132 action to comply with PPACA, the office may report such
133 potential violation to the federal Department of Health and
134 Human Resources.
135 (4) The department's Division of Consumer Services may
136 respond to complaints by consumers relating to a requirement of
137 PPACA as authorized under s. 20.121(2)(h), and report apparent
138 or potential violations to the office and to the federal
139 Department of Health and Human Services.
140 (5) A determination made by the office or department
141 pursuant to this section regarding compliance with PPACA does
142 not constitute a determination that affects the substantial
143 interests of any party for purposes of chapter 120.
144 Section 3. Effective October 1, 2014, subsection (2) of
145 section 624.34, Florida Statutes, is amended to read:

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146 624.34 Authority of Department of Law Enforcement to accept
147 fingerprints of, and exchange criminal history records with
148 respect to, certain persons.—
149 (2) The Department of Law Enforcement may accept
150 fingerprints of individuals who apply for a license as an agent,
151 customer representative, adjuster, service representative,
152 navigator, or managing general agent or the fingerprints of the
153 majority owner, sole proprietor, partners, officers, and
154 directors of a corporation or other legal entity that applies
155 for licensure with the department or office under ~~the provisions~~
156 ~~of~~ the Florida Insurance Code.
157 Section 4. Effective October 1, 2014, subsection (1) of
158 section 626.022, Florida Statutes, is amended to read:
159 626.022 Scope of part.—
160 (1) This part applies ~~as~~ to insurance agents, service
161 representatives, adjusters, navigators, and insurance agencies;
162 ~~as~~ to any and all kinds of insurance; and ~~as~~ to stock insurers,
163 mutual insurers, reciprocal insurers, and all other types of
164 insurers, except that:
165 (a) It does not apply ~~as~~ to reinsurance, except that ss.
166 626.011-626.022, ss. 626.112-626.181, ss. 626.191-626.211, ss.
167 626.291-626.301, s. 626.331, ss. 626.342-626.521, ss. 626.541-
168 626.591, and ss. 626.601-626.711 shall apply ~~as~~ to reinsurance
169 intermediaries as defined in s. 626.7492.
170 (b) The applicability of this chapter ~~as~~ to fraternal
171 benefit societies shall be as provided in chapter 632.
172 (c) It does not apply to a bail bond agent, as defined in
173 s. 648.25, except as provided in chapter 648 or chapter 903.
174 (d) It ~~This part~~ does not apply to a certified public

175 accountant licensed under chapter 473 who is acting within the
176 scope of the practice of public accounting, as defined in s.
177 473.302 if~~, provided that~~ the activities of the certified public
178 accountant are limited to advising a client of the necessity of
179 obtaining insurance, the amount of insurance needed, or the line
180 of coverage needed, and if ~~provided that~~ the certified public
181 accountant does not directly or indirectly receive or share in
182 any commission or referral fee.
183 Section 5. Effective October 1, 2014, subsection (9) of
184 section 626.207, Florida Statutes, is amended to read:
185 626.207 Disqualification of applicants and licensees;
186 penalties against licensees; rulemaking authority.—
187 (9) Section 112.011 does not apply to ~~any~~ applicants for
188 licensure under the Florida Insurance Code, including, but not
189 limited to, agents, agencies, adjusters, adjusting firms,
190 customer representatives, navigators, or managing general
191 agents.
192 Section 6. The Division of Law Revision and Information is
193 directed to create part XII of chapter 626, Florida Statutes,
194 consisting of s. 626.995, Florida Statutes, and to title that
195 part as “Navigators.”
196 Section 7. Effective October 1, 2014, section 626.995,
197 Florida Statutes, is created to read:
198 626.995 Qualification and licensure of navigators.—
199 (1) All navigators must be licensed and have such licenses
200 renewed, continued, reinstated, or terminated as prescribed for
201 licensure or appointment under parts I and IV of this chapter.
202 Parts VIII and IX of this chapter also apply to navigators.
203 (2) DEFINITIONS.—As used in this section, the term:

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204 (a) “Exchange” means an approved state, federal, or
205 partnership exchange operating in this state pursuant 42 U.S.C.
206 s. 18031.
207 (b) “Facilitate,” with regard to the selection of a
208 qualified health plan, means providing assistance and
209 information to an individual regarding choices for enrollment in
210 a qualified health plan available through an exchange.
211 (c) “Navigator” means an individual, as defined in 45
212 C.F.R. s. 155.20, who provides the services and performs the
213 duties of a navigator as set forth in 45 C.F.R. s. 155.210(e).
214 (d) “Qualified health plan” means a health plan as defined
215 in 45 C.F.R. s. 155.20 which has been approved to be offered
216 through an exchange.
217 (3) LICENSE REQUIRED.—
218 (a) An individual or entity may not act, offer to act, or
219 advertise any service as a navigator in this state unless
220 licensed as a navigator by the department pursuant to this
221 section.
222 (b) A navigator license may not be issued unless the
223 applicant establishes, to the satisfaction of the department,
224 that he or she has the background, experience, knowledge, and
225 competency that will enable him or her to deliver unbiased and
226 accurate information to individuals in this state seeking to
227 obtain affordable health insurance coverage through an exchange
228 and meets the license qualifications required under this
229 section.
230 (c) Each license application must be accompanied by a
231 nonrefundable $50 application filing fee.
232 (4) LICENSE QUALIFICATIONS.—An individual may not be

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233 licensed as a navigator unless the individual meets all of the
234 following qualifications:
235 (a) Is at least 18 years of age.
236 (b) Has submitted a license application to the department
237 on a form approved by the department and provided such
238 information as the department deems necessary to determine the
239 applicant's fitness to be licensed as a navigator in this state.
240 (c) Has been subjected to a criminal history and regulatory
241 background check following the submission fingerprints to the
242 department and is not disqualified as provided under part I of
243 this chapter.
244 (d) Has not committed any act that constitutes grounds for
245 refusal, suspension, or revocation as provided under part I of
246 this chapter.
247 (e) Has successfully completed a 10-hour classroom course,
248 satisfactory to the department, at a school or college or
249 extension division thereof, or other authorized course of study
250 approved by the department. Courses must include instruction on
251 the subject matter of health insurance plans, health maintenance
252 organizations, unauthorized entities engaging in the business of
253 insurance, the Patient Protection Affordable Care Act, Pub. L.
254 No. 111-152, the availability of premium tax credits under 26
255 U.S.C. s. 36B, cost-sharing reductions under 45 C.F.R s.
256 155.305, prohibitions against the unlicensed transaction of
257 insurance, and ethics.
258 (f) Has passed an examination authorized by the department.
259 (5) NAVIGATOR CONDUCT.—
260 (a) A navigator shall:
261 1. Facilitate the selection of a qualified health plan

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262 through an exchange by providing factually accurate information
263 to an individual regarding qualified health plans, the
264 availability of premium tax credits under 26 U.S.C. s. 36B, and
265 cost sharing reductions under 45 C.F.R. s. 155.305;
266 2. Inform an individual that the insurance agent, insurance
267 company, or employer can provide information and assistance
268 regarding coverage upon determining that an individual has
269 existing health insurance coverage purchased outside the
270 exchange; and
271 3. Indicate he or she is not permitted to recommend the
272 purchase of, give opinions about, or advise that any health plan
273 is superior to or worse than another health plan.
274 (b) A navigator may not:
275 1. Conduct activities that may only be performed by a
276 licensed insurance agent;
277 2. Solicit, negotiate, or sell health insurance;
278 3. Recommend the purchase of, give opinions about, or
279 advise that any health plan is superior to or worse than
280 another;
281 4. Violate the provisions of 42 U.S.C. s. 18031 or 45
282 C.F.R. part 155;
283 5. Receive compensation or anything of value from an
284 insurer, health plan, business, or consumer in connection with
285 performing activities of a navigator, other than from an entity
286 or individual who has received a navigator grant pursuant to 45
287 C.F.R. s. 155.210; or
288 6. Recommend or assist with the cancellation of coverage
289 purchased outside of the exchange.
290 (c) DISCIPLINARY ACTIONS.—The department may suspend,

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291 revoke, or refuse to issue a navigator license or may fine or
292 place on probation a licensee for a violation of this section in
293 the same manner as prescribed under chapter 626 for insurance
294 representatives.
295 (6) DISCONTINUANCE OF LICENSE.—If 42 U.S.C. s. 18031 or 45
296 C.F.R. part 155 no longer authorizes an exchange to validly
297 operate in this state or no longer requires navigators to assist
298 individuals, the department shall discontinue licensing
299 navigators under this section and existing licenses shall
300 automatically expire 30 days after notice is given to the
301 licensee.
302 (7) CONCURRENT LICENSURE PROHIBITED.—An individual may not
303 be concurrently licensed as a navigator and an insurance agent.
304 (8) RULES.—The department may adopt rules to administer
305 this section.
306 Section 8. Section 627.402, Florida Statutes, is amended to
307 read:
308 627.402 Definitions~~; specified certificates not included~~.—
309 As used in this part, the term:
310 (1) “Grandfathered health plan” has the same meaning as
311 provided in 42 U.S.C. s. 18011, subject to the conditions for
312 maintaining status as a grandfathered health plan specified in
313 regulations adopted by the federal Department of Health and
314 Human Services in 45 C.F.R. s. 147.140.
315 (2) “Nongrandfathered health plan” is a health insurance
316 policy or health maintenance organization contract that is not a
317 grandfathered health plan and does not provide the benefits or
318 coverages specified under s. 627.6561(5)(b)-(e).
319 (3)~~(1)~~ “Policy” means a written contract of insurance or

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320 written agreement for or effecting insurance, or the certificate
321 thereof, by whatever name called, and includes all clauses,
322 riders, endorsements, and papers <u>that</u> ~~which~~ are a part thereof.
323 ~~(2)~~ The <u>term</u> ~~word~~ “certificate” as used in this <u>subsection</u>
324 ~~section~~ does not include certificates as to group life or health
325 insurance or as to group annuities issued to individual
326 insureds.
327 <u>(4) “PPACA” means the Patient Protection and Affordable</u>
328 <u>Care Act, Pub. L. No. 111-148, as amended by the Health Care and</u>
329 <u>Education Reconciliation Act of 2010, Pub. L. No. 111-152, and</u>
330 <u>regulations adopted pursuant to those acts.</u>
331 Section 9. Subsections (2), (6), and (7) of section
332 627.410, Florida Statutes, are amended, and subsection (9) is
333 added to that section, to read:
334 627.410 Filing, approval of forms.—
335 (2) Every such filing must be made <u>at least</u> ~~not less than~~
336 30 days in advance of any such use or delivery. At the
337 expiration of <u>the</u> ~~such~~ 30 days, the form ~~so~~ filed will be deemed
338 approved unless prior thereto it has been affirmatively approved
339 or disapproved by order of the office. The approval of ~~any~~ such
340 form by the office constitutes a waiver of any unexpired portion
341 of such waiting period. The office may extend ~~by not more than~~
342 ~~an additional 15 days~~ the period within which it may ~~so~~
343 affirmatively approve or disapprove ~~any~~ such form <u>by up to 15</u>
344 <u>days</u>~~,~~ by giving notice of such extension before expiration of
345 the initial 30-day period. At the expiration of ~~any~~ such
346 <u>extended</u> period ~~as so extended~~, and in the absence of ~~such~~ prior
347 affirmative approval or disapproval, ~~any~~ such form shall be
348 deemed approved.

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349 (6)(a) An insurer may ~~shall~~ not deliver, ~~or~~ issue for
350 delivery, or renew in this state any health insurance policy
351 form until it has filed with the office a copy of every
352 applicable rating manual, rating schedule, change in rating
353 manual, and change in rating schedule; if rating manuals and
354 rating schedules are not applicable, the insurer must file with
355 the office applicable premium rates and any change in applicable
356 premium rates. This paragraph does not apply to group health
357 insurance policies, effectuated and delivered in this state,
358 insuring groups of 51 or more persons, except for Medicare
359 supplement insurance, long-term care insurance, and any coverage
360 under which the increase in claim costs over the lifetime of the
361 contract due to advancing age or duration is prefunded in the
362 premium.
363 (b) The commission may establish by rule, for each type of
364 health insurance form, procedures to be used in ascertaining the
365 reasonableness of benefits in relation to premium rates and may,
366 by rule, exempt from any requirement of paragraph (a) any health
367 insurance policy form or type thereof, ~~(~~as specified in such
368 rule,~~)~~ to which form or type such requirements may not be
369 practically applied or to which form or type the application of
370 such requirements is not desirable or necessary for the
371 protection of the public. With respect to any health insurance
372 policy form or type thereof which is exempted by rule from any
373 requirement of paragraph (a), premium rates filed pursuant to
374 ss. 627.640 and 627.662 are ~~shall be~~ for informational purposes.
375 (c) Every filing made pursuant to this subsection shall be
376 made within the same time period ~~provided in~~, and shall be
377 deemed to be approved under the same conditions, as ~~those~~

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378 provided in~~,~~ subsection (2).
379 (d) Every filing made pursuant to this subsection, except
380 disability income policies and accidental death policies, are
381 ~~shall be~~ prohibited from applying the following rating
382 practices:
383 1. Select and ultimate premium schedules.
384 2. Premium class definitions that ~~which~~ classify insured
385 based on year of issue or duration since issue.
386 3. Attained age premium structures on policy forms under
387 which more than 50 percent of the policies are issued to persons
388 age 65 or over.
389 (e) Except as provided in subparagraph 1., an insurer shall
390 continue to make available for purchase any individual policy
391 form issued on or after October 1, 1993. A policy form is ~~shall~~
392 not ~~be~~ considered to be available for purchase unless the
393 insurer has actively offered it for sale during ~~in~~ the previous
394 12 months.
395 1. An insurer may discontinue the availability of a policy
396 form if the insurer provides its decision to the office in
397 writing ~~its decision~~ at least 30 days before ~~prior to~~
398 discontinuing the availability of the form of the policy or
399 certificate. After receipt of the notice by the office, the
400 insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or
401 certificate form for sale in this state.
402 2. An insurer that discontinues the availability of a
403 policy form pursuant to subparagraph 1. may ~~shall~~ not file for
404 approval a new policy form providing ~~similar~~ benefits similar to
405 ~~as~~ the discontinued form for ~~a period of~~ 5 years after the
406 insurer provides notice to the office of the discontinuance. The

period of discontinuance may be reduced if the office determines that a shorter period is appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.

(7)~~(a)~~ Each insurer subject to ~~the requirements of~~ subsection (6) shall make an annual filing with the office within ~~no later than~~ 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. ~~The office,~~ After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a)~~(b)~~ The filing ~~required by this subsection~~ shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted ~~promulgated~~ by the commission.

2. If no rate change is proposed, a filing that ~~which~~ consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

436 (b)~~(c)~~ As used in this section, the term "actuary" means an
437 individual who is a member of the Society of Actuaries or the
438 American Academy of Actuaries. If an insurer does not employ or
439 otherwise retain the services of an actuary, the insurer's
440 certification shall be prepared by insurer personnel or
441 consultants who have ~~with~~ a minimum of 5 years' experience in
442 insurance ratemaking. The chief executive officer of the insurer
443 shall review and sign the certification indicating his or her
444 agreement with its conclusions.
445 (c)~~(d)~~ If at the time a filing is required ~~under this~~
446 ~~section~~ an insurer is in the process of completing a rate
447 review, the insurer may apply to the office for an extension of
448 up to an additional 30 days in which to make the filing. The
449 request for extension must be received by the office by ~~no later~~
450 ~~than~~ the date the filing is due.
451 (d)~~(e)~~ If an insurer fails to meet the filing requirements
452 of this subsection and does not submit the filing within 60 days
453 after ~~following~~ the date the filing is due, the office may, in
454 addition to any other penalty authorized by law, order the
455 insurer to discontinue the issuance of policies for which the
456 required filing was not made~~,~~ until such time as the office
457 determines that the required filing is properly submitted.
458 (9) For plan years 2014 and 2015, nongrandfathered health
459 plans for the individual or small group market are not subject
460 to rate review or approval by the office. An insurer or health
461 maintenance organization issuing or renewing such health plans
462 shall file rates and any change in rates with the office as
463 required by paragraph (6)(a), but the filing and rates are not
464 subject to subsection (2), paragraphs (b), (c), or (d) of

465 subsection (6), or subsection (7).
466 (a) For each individual and small group nongrandfathered
467 health plan, an insurer or health maintenance organization shall
468 include a notice describing or illustrating the estimated impact
469 of PPACA on monthly premiums with the delivery of the policy or
470 contract or, upon renewal, the premium renewal notice. The
471 notice must be in a format established by rule of the
472 commission. All notices shall be submitted to the office for
473 informational purposes by September 1, 2013. The notice is
474 required only for the first issuance or renewal of the policy or
475 contract on or after January 1, 2014.
476 (b) The information provided in the notice shall be based
477 on the statewide average premium for the policy or contract for
478 the bronze, silver, gold, or platinum level plan, whichever is
479 applicable to the policy or contract, and provide an estimate of
480 the following effects of PPACA requirements:
481 1. The dollar amount of the premium which is attributable
482 to the impact of guaranteed issuance of coverage. This estimate
483 must include, but is not required to itemize, the impact of the
484 requirement that rates be based on factors unrelated to health
485 status, how the individual coverage mandate and subsidies
486 provided in the health insurance exchange established in this
487 state pursuant to PPACA affect the impact of guaranteed issuance
488 of coverage, and estimated reinsurance credits.
489 2. The dollar amount of the premium which is attributable
490 to fees, taxes, and assessments.
491 3. For individual policies or contracts, the dollar amount
492 of the premium increase or decrease from the premium that would
493 have otherwise been due which is attributable to the combined

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494 impact of the requirement that rates for age be limited to a 3-
495 to-1 ratio and the prohibition against using gender as a rating
496 factor. This estimate must be displayed for the average rates
497 for male and female insureds, respectively, for the following
498 three age categories: age 21 years to 29 years, age 30 years to
499 54 years, and age 55 years to 64 years.
500 4. The dollar amount which is attributable to the
501 requirement that essential health benefits be provided and to
502 meet the required actuarial value for the product, as compared
503 to the statewide average premium for the policy or contract for
504 the plan issued by that insurer or organization that has the
505 highest enrollment in the individual or small group market on
506 July 1, 2013, whichever is applicable. The statewide average
507 premiums for the plan that has the highest enrollment must
508 include all policyholders, including those that have health
509 conditions that increase the standard premium.
510 (c) The office, in consultation with the department, shall
511 develop a summary of the estimated impact of PPACA on monthly
512 premiums as contained in the notices submitted by insurers and
513 health maintenance organizations, which must be available on the
514 respective websites of the office and department by October 1,
515 2013.
516 (d) This subsection is repealed on March 1, 2015.
517 Section 10. Subsection (4) is added to section 627.411,
518 Florida Statutes, to read:
519 627.411 Grounds for disapproval.—
520 (4) The provisions of this section which apply to rates,
521 rating practices, or the relationship of benefits to the premium
522 charged do not apply to nongrandfathered health plans described

523 in s. 627.410(9). This subsection is repealed on March 1, 2015.
524 Section 11. Paragraph (a) of subsection (3) of section
525 627.6425, Florida Statutes, is amended to read:
526 627.6425 Renewability of individual coverage.—
527 (3)(a) If ~~In any case in which~~ an insurer decides to
528 discontinue offering a particular policy form for health
529 insurance coverage offered in the individual market, coverage
530 under such form may be discontinued by the insurer only if:
531 1. The insurer provides notice to each covered individual
532 provided coverage under this policy form in the individual
533 market of such discontinuation at least 90 days before ~~prior to~~
534 the date of the nonrenewal of such coverage;
535 2. The insurer offers to each individual in the individual
536 market provided coverage under this policy form the option to
537 purchase any other individual health insurance coverage
538 currently being offered by the insurer for individuals in such
539 market in the state; and
540 3. In exercising the option to discontinue coverage of a
541 ~~this~~ policy form and in offering the option of coverage under
542 subparagraph 2., the insurer acts uniformly without regard to
543 any health-status-related factor of enrolled individuals or
544 individuals who may become eligible for such coverage. If a
545 policy form covers both grandfathered and nongrandfathered
546 health plans, an insurer may nonrenew coverage only for the
547 nongrandfathered health plans, in which case the requirements of
548 subparagraphs 1. and 2. apply only to the nongrandfathered
549 health plans. As used in this subparagraph, the terms
550 “grandfathered health plan” and “nongrandfathered health plan”
551 have the same meaning as provided in s. 627.402.

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552 Section 12. Section 627.6484, Florida Statutes, is amended
553 to read:
554 627.6484 Dissolution of association; termination of
555 enrollment; availability of other coverage.—
556 (1) The association shall accept applications for insurance
557 only until June 30, 1991, after which date no further
558 applications may be accepted.
559 (2) Coverage for each policyholder of the association
560 terminates at midnight, June 30, 2014, or on the date that
561 health insurance coverage is effective with another insurer,
562 whichever occurs first, and such terminated coverage may not be
563 renewed.
564 (3) The association must provide assistance to each
565 policyholder concerning how to obtain health insurance coverage.
566 Such assistance must include the identification of insurers and
567 health maintenance organizations offering coverage in the
568 individual market, including inside and outside of the health
569 insurance exchange established in this state pursuant to PPACA
570 as defined in s. 627.402, a basic explanation of the levels of
571 coverage available, and specific information relating to local
572 and online sources from which a policyholder may obtain detailed
573 policy and premium comparisons and directly obtain coverage.
574 (4) The association shall provide written notice to all
575 policyholders by September 1, 2013, which informs each
576 policyholder with respect to:
577 (a) The date that coverage with the association is
578 terminated and that such coverage may not be renewed.
579 (b) The opportunity for the policyholder to obtain
580 individual health insurance coverage on a guaranteed-issue

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581 basis, regardless of the policyholder’s health status, from any
582 health insurer or health maintenance organization that offers
583 coverage in the individual market, including the dates of open
584 enrollment periods for obtaining such coverage.
585 (c) How to access coverage through the health insurance
586 exchange established for this state and the potential for
587 obtaining reduced premiums and cost-sharing provisions depending
588 on the policyholder’s family income level.
589 (d) Contact information for a representative of the
590 association who is able to provide additional information about
591 obtaining individual health insurance coverage both inside and
592 outside of the Health Insurance Exchange.
593 (5) After termination of coverage, the association must
594 continue to receive and process timely submitted claims in
595 accordance with the laws of this state.
596 (6) By March 15, 2015, the association must determine the
597 final assessment to be collected from insurers for funding
598 claims and administrative expenses of the association or, if
599 surplus funds remain, determine the refund amount to be provided
600 to each insurer based on the same pro rata formula used in
601 determining each insurer’s assessment.
602 (7) By September 1, 2015, the board must:
603 (a) Complete performance of all program responsibilities.
604 (b) Sell or otherwise dispose of all physical assets of the
605 association.
606 (c) Make a final accounting of the finances of the
607 association.
608 (d) Transfer all records to the Department of Financial
609 Services, which shall serve as custodian of such records.

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610 (e) Execute a legal dissolution of the association and
611 report such action to the Chief Financial Officer, the Insurance
612 Commissioner, the President of the Senate, and the Speaker of
613 the House of Representatives. ~~Upon receipt of an application for~~
614 ~~insurance, the association shall issue coverage for an eligible~~
615 ~~applicant. When appropriate, the administrator shall forward a~~
616 ~~copy of the application to a market assistance plan created by~~
617 ~~the office, which shall conduct a diligent search of the private~~
618 ~~marketplace for a carrier willing to accept the application.~~
619 ~~(2) The office shall, after consultation with the health~~
620 ~~insurers licensed in this state, adopt a market assistance plan~~
621 ~~to assist in the placement of risks of Florida Comprehensive~~
622 ~~Health Association applicants. All health insurers and health~~
623 ~~maintenance organizations licensed in this state shall~~
624 ~~participate in the plan.~~
625 ~~(3) Guidelines for the use of such program shall be a part~~
626 ~~of the association's plan of operation. The guidelines shall~~
627 ~~describe which types of applications are to be exempt from~~
628 ~~submission to the market assistance plan. An exemption shall be~~
629 ~~based upon a determination that due to a specific health~~
630 ~~condition an applicant is ineligible for coverage in the~~
631 ~~standard market. The guidelines shall also describe how the~~
632 ~~market assistance plan is to be conducted, and how the periodic~~
633 ~~reviews to depopulate the association are to be conducted.~~
634 ~~(4) If a carrier is found through the market assistance~~
635 ~~plan, the individual shall apply to that company. If the~~
636 ~~individual's application is accepted, association coverage shall~~
637 ~~terminate upon the effective date of the coverage with the~~
638 ~~private carrier. For the purpose of applying a preexisting~~

639 ~~condition limitation or exclusion, any carrier accepting a risk~~
640 ~~pursuant to this section shall provide coverage as if it began~~
641 ~~on the date coverage was effectuated on behalf of the~~
642 ~~association, and shall be indemnified by the association for~~
643 ~~claims costs incurred as a result of utilizing such effective~~
644 ~~date.~~
645 ~~(5) The association shall establish a policyholder~~
646 ~~assistance program by July 1, 1991, to assist in placing~~
647 ~~eligible policyholders in other coverage programs, including~~
648 ~~Medicare and Medicaid.~~
649 Section 13. Section 627.64872, Florida Statutes, is
650 repealed.
651 Section 14. Effective October 1, 2015, sections 627.648,
652 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649,
653 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida
654 Statutes, are repealed.
655 Section 15. Paragraph (a) of subsection (3) of section
656 627.6571, Florida Statutes, is amended to read:
657 627.6571 Guaranteed renewability of coverage.—
658 (3)(a) An insurer may discontinue offering a particular
659 policy form of group health insurance coverage offered in the
660 small-group market or large-group market only if:
661 1. The insurer provides notice to each policyholder
662 provided coverage under ~~of~~ this policy form ~~in such market~~, and
663 to participants and beneficiaries covered under such coverage,
664 of such discontinuation at least 90 days before ~~prior to~~ the
665 date of the nonrenewal of such coverage;
666 2. The insurer offers to each policyholder provided
667 coverage under ~~of~~ this policy form ~~in such market~~ the option to

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668 purchase all, or in the case of the large-group market, any
669 other health insurance coverage currently being offered by the
670 insurer in such market; and
671 3. In exercising the option to discontinue coverage of this
672 form and in offering the option of coverage under subparagraph
673 2., the insurer acts uniformly without regard to the claims
674 experience of those policyholders or any health-status-related
675 factor that relates to any participants or beneficiaries covered
676 or new participants or beneficiaries who may become eligible for
677 such coverage. If a policy form covers both grandfathered and
678 nongrandfathered health plans, an insurer may nonrenew coverage
679 only for nongrandfathered health plans, in which case the
680 requirements of subparagraphs 1. and 2. apply only to the
681 nongrandfathered health plans. As used in this subparagraph, the
682 terms "grandfathered health plan" and "nongrandfathered health
683 plan" have the same meanings as provided in s. 627.402.
684 Section 16. Paragraphs (j) through (w) of subsection (3) of
685 section 627.6699, Florida Statutes, are redesignated as
686 paragraphs (k) through (x), respectively, a new paragraph (j) is
687 added to that subsection, present paragraphs (v) and (w) of that
688 subsection are amended, and paragraph (b) of subsection (6) is
689 amended, to read:
690 627.6699 Employee Health Care Access Act.—
691 (3) DEFINITIONS.—As used in this section, the term:
692 (j) "Grandfathered health plan" and "nongrandfathered
693 health plan" have the same meaning as provided in s. 627.402.
694 (w) ~~(v)~~ "Small employer" means, in connection with a health
695 benefit plan with respect to a calendar year and a plan year: ~~,~~
696 1. For a grandfathered health plan, any person, sole

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697 proprietor, self-employed individual, independent contractor,
698 firm, corporation, partnership, or association that is actively
699 engaged in business, has its principal place of business in this
700 state, employed an average of at least 1 but not more than 50
701 eligible employees on business days during the preceding
702 calendar year, the majority of whom were employed in this state,
703 employs at least 1 employee on the first day of the plan year,
704 and is not formed primarily for purposes of purchasing
705 insurance. In determining the number of ~~eligible~~ employees,
706 companies that are an affiliated group as defined in s. 1504(a)
707 of the Internal Revenue Code of 1986, as amended, are considered
708 a single employer. For purposes of this section, a sole
709 proprietor, an independent contractor, or a self-employed
710 individual is considered a small employer only if all of the
711 conditions and criteria established in this section are met.
712 2. For a nongrandfathered health plan, any employer that
713 has its principal place of business in this state, employed an
714 average of at least 1 but not more than 50 employees on business
715 days during the preceding calendar year, and employs at least 1
716 employee on the first day of the plan year. As used in this
717 subparagraph, the terms "employee" and "employer" have the same
718 meaning as provided in s. 3 of the Employee Retirement Income
719 Security Act of 1974, as amended, 29 U.S.C. 1002.
720 (x) ~~(w)~~ "Small employer carrier" means a carrier that offers
721 health benefit plans covering ~~eligible~~ employees of one or more
722 small employers.
723 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
724 (b) For all small employer health benefit plans that are
725 subject to this section and ~~are~~ issued by small employer

726 carriers on or after January 1, 1994, premium rates for health
727 benefit plans ~~subject to this section~~ are subject to the
728 following:
729 1. Small employer carriers must use a modified community
730 rating methodology in which the premium for each small employer
731 is ~~must be~~ determined solely on the basis of the eligible
732 employee’s and eligible dependent’s gender, age, family
733 composition, tobacco use, or geographic area as determined under
734 paragraph (5)(j) and in which the premium may be adjusted as
735 permitted by this paragraph. A small employer carrier is not
736 required to use gender as a rating factor for a nongrandfathered
737 health plan.
738 2. Rating factors related to age, gender, family
739 composition, tobacco use, or geographic location may be
740 developed by each carrier to reflect the carrier’s experience.
741 The factors used by carriers are subject to office review and
742 approval.
743 3. Small employer carriers may not modify the rate for a
744 small employer for 12 months from the initial issue date or
745 renewal date, unless the composition of the group changes or
746 benefits are changed. However, a small employer carrier may
747 modify the rate one time within the ~~prior to~~ 12 months after the
748 initial issue date for a small employer who enrolls under a
749 previously issued group policy that has a common anniversary
750 date for all employers covered under the policy if:
751 a. The carrier discloses to the employer in a clear and
752 conspicuous manner the date of the first renewal and the fact
753 that the premium may increase on or after that date.
754 b. The insurer demonstrates to the office that efficiencies

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755 in administration are achieved and reflected in the rates
756 charged to small employers covered under the policy.
757 4. A carrier may issue a group health insurance policy to a
758 small employer health alliance or other group association with
759 rates that reflect a premium credit for expense savings
760 attributable to administrative activities being performed by the
761 alliance or group association if such expense savings are
762 specifically documented in the insurer's rate filing and are
763 approved by the office. Any such credit may not be based on
764 different morbidity assumptions or on any other factor related
765 to the health status or claims experience of any person covered
766 under the policy. ~~Nothing in~~ This subparagraph does not exempt
767 ~~exempts~~ an alliance or group association from licensure for ~~any~~
768 activities that require licensure under the insurance code. A
769 carrier issuing a group health insurance policy to a small
770 employer health alliance or other group association shall allow
771 any properly licensed and appointed agent of that carrier to
772 market and sell the small employer health alliance or other
773 group association policy. Such agent shall be paid the usual and
774 customary commission paid to any agent selling the policy.
775 5. Any adjustments in rates for claims experience, health
776 status, or duration of coverage may not be charged to individual
777 employees or dependents. For a small employer's policy, such
778 adjustments may not result in a rate for the small employer
779 which deviates more than 15 percent from the carrier's approved
780 rate. Any such adjustment must be applied uniformly to the rates
781 charged for all employees and dependents of the small employer.
782 A small employer carrier may make an adjustment to a small
783 employer's renewal premium, up to ~~not to exceed~~ 10 percent

784 annually, due to the claims experience, health status, or
785 duration of coverage of the employees or dependents of the small
786 employer. Semiannually, small group carriers shall report
787 information on forms adopted by rule by the commission, to
788 enable the office to monitor the relationship of aggregate
789 adjusted premiums actually charged policyholders by each carrier
790 to the premiums that would have been charged by application of
791 the carrier's approved modified community rates. If the
792 aggregate resulting from the application of such adjustment
793 exceeds the premium that would have been charged by application
794 of the approved modified community rate by 4 percent for the
795 current reporting period, the carrier shall limit the
796 application of such adjustments only to minus adjustments
797 beginning within ~~not more than~~ 60 days after the report is sent
798 to the office. For any subsequent reporting period, if the total
799 aggregate adjusted premium actually charged does not exceed the
800 premium that would have been charged by application of the
801 approved modified community rate by 4 percent, the carrier may
802 apply both plus and minus adjustments. A small employer carrier
803 may provide a credit to a small employer's premium based on
804 administrative and acquisition expense differences resulting
805 from the size of the group. Group size administrative and
806 acquisition expense factors may be developed by each carrier to
807 reflect the carrier's experience and are subject to office
808 review and approval.
809 6. A small employer carrier rating methodology may include
810 separate rating categories for one dependent child, for two
811 dependent children, and for three or more dependent children for
812 family coverage of employees having a spouse and dependent

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813 children or employees having dependent children only. A small
814 employer carrier may have fewer, but not greater, numbers of
815 categories for dependent children than those specified in this
816 subparagraph.
817 7. Small employer carriers may not use a composite rating
818 methodology to rate a small employer with fewer than 10
819 employees. For the purposes of this subparagraph, the term ~~a~~
820 “composite rating methodology” means a rating methodology that
821 averages the impact of the rating factors for age and gender in
822 the premiums charged to all of the employees of a small
823 employer.
824 8.~~a.~~ A carrier may separate the experience of small
825 employer groups with fewer ~~less~~ than 2 eligible employees from
826 the experience of small employer groups with 2-50 eligible
827 employees for purposes of determining an alternative modified
828 community rating.
829 a.~~b.~~ If a carrier separates the experience of small
830 employer groups ~~as provided in sub-subparagraph a.~~, the rate to
831 be charged to small employer groups of fewer ~~less~~ than 2
832 eligible employees may not exceed 150 percent of the rate
833 determined for small employer groups of 2-50 eligible employees.
834 However, the carrier may charge excess losses of the experience
835 pool consisting of small employer groups with less than 2
836 eligible employees to the experience pool consisting of small
837 employer groups with 2-50 eligible employees so that all losses
838 are allocated and the 150-percent rate limit on the experience
839 pool consisting of small employer groups with less than 2
840 eligible employees is maintained.
841 b. Notwithstanding s. 627.411(1), the rate to be charged to

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842 a small employer group of fewer than 2 eligible employees,
843 insured as of July 1, 2002, may be up to 125 percent of the rate
844 determined for small employer groups of 2-50 eligible employees
845 for the first annual renewal and 150 percent for subsequent
846 annual renewals.
847 9. A carrier shall separate the experience of grandfathered
848 health plans from nongrandfathered health plans for determining
849 rates.
850 Section 17. Paragraph (f) is added to subsection (3) of
851 section 641.31, Florida Statutes, to read:
852 641.31 Health maintenance contracts.—
853 (3)
854 (f)1. For plan years 2014 and 2015, nongrandfathered health
855 plans for the individual or small group market are not subject
856 to rate review or approval by the office. A health maintenance
857 organization that issues or renews a nongrandfathered health
858 plan is subject to s. 627.410(9). As used in this paragraph, the
859 terms "PPACA" and "nongrandfathered health plan" have the same
860 meanings as those terms are defined in s. 627.402.
861 2. This paragraph is repealed effective March 1, 2015.
862 Section 18. Except as otherwise expressly provided in this
863 act, this act shall take effect upon becoming a law.

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