A bill to be entitled

An act relating to health insurance; creating s. 624.25, F.S.; providing for applicability of Florida Insurance Code and rules with respect to Patient Protection and Affordable Care Act (PPACA); creating s. 624.26, F.S.; authorizing the Office of Insurance Regulation to review forms and perform market conduct examinations for compliance with PPACA and to report potential violations to the United States Department of Health and Human Services; authorizing the Division of Consumer Services of the Department of Financial Services to respond to complaints related to PPACA and to report violations to the office and the United States Department of Health and Human Services; providing that certain determinations by the office or the Department of Financial Services related to compliance with PPACA are not decisions that affect a party's substantial interests for purposes of ch. 120, F.S.; amending s. 624.34, F.S.; conforming provisions with respect to the registration of navigators under the Florida Insurance Code; creating part XII of ch. 626, F.S., relating to navigators; providing for the scope of the part; defining terms; requiring the registration of navigators with the Department of Financial Services; providing the purpose for such registration; providing qualifications for registration; providing for submission of a written application; specifying fees; requiring an applicant

to submit fingerprints and pay a processing fee; specifying criteria for disqualification from registration; authorizing the department to adopt rules establishing disqualifying time periods; requiring the department to have a publicly available list of navigators and to report certain information to the exchange; requiring a navigator to notify the department of a change of specified identifying information; prohibiting specified conduct; providing grounds for denial, suspension, or revocation of registration; providing for administrative fines and other disciplinary actions; authorizing the department to adopt rules; amending s. 627.402, F.S.; defining the terms "grandfathered health plan," "nongrandfathered health plan," and "PPACA"; amending s. 627.410, F.S.; providing an exception to the prohibition against an insurer issuing a new policy form after discontinuing the availability of a similar policy form when the form does not comply with PPACA; requiring the experience of grandfathered health plans and nongrandfathered health plans to be separated; providing that nongrandfathered health plans are not subject to rate review or approval by the office; specifying that such rates for such health plans must be filed with the office and are exempt from other specified rate requirements; requiring insurers and health maintenance organizations issuing such health plans to include a notice of the estimated impact of

PPACA on monthly premiums with the first issuance or renewal of the policy; requiring the Financial Services Commission to adopt the format for the notice by rule; requiring the notice to be filed with the office for informational purposes; providing for the calculation of the estimated premium impact; requiring the office, in consultation with the Department of Financial Services, to develop a summary of the impact to be made available on their respective websites; providing for future repeal; amending s. 627.411, F.S.; providing that grounds for disapproval of rates do not apply to nongrandfathered health plans; providing for future repeal; amending s. 627.642, F.S.; conforming a cross-reference; amending s. 627.6425, F.S.; allowing an insurer to nonrenew coverage only for all nongrandfathered health plans under certain conditions; amending s. 627.6484, F.S.; providing that coverage for each policyholder of the Florida Comprehensive Health Association terminates on a specified date; requiring the association to provide assistance to policyholders; requiring the association to notify policyholders of termination of coverage and provide information concerning how to obtain other coverage; requiring the association to impose a final assessment or provide a refund to member insurers, sell or dispose of physical assets, perform a final accounting, legally dissolve the association, submit a required report, transfer all records to the

Department of Financial Services, and transfer remaining funds of the association to the Chief Financial Officer for deposit in the General Revenue Fund; repealing s. 627.64872, F.S., relating to the Florida Health Insurance Plan; providing for the future repeal of ss. 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, F.S., relating to the Florida Comprehensive Health Association Act, definitions, termination of enrollment and availability of other coverage, eligibility, the Florida Comprehensive Health Association, the Disease Management Program, the administrator of the health insurance plan, participation of insurers, insurer assessments, deferment, and assessment limitations, issuing of policies, minimum benefits coverage and exclusions, premiums, and deductibles, and reporting by insurers and third-party administrators, respectively; amending s. 627.657, F.S.; conforming a cross-reference; amending s. 627.6571, F.S.; allowing an insurer to nonrenew coverage only for all nongrandfathered health plans under certain conditions; amending s. 627.6699, F.S.; adding and revising definitions used in the Employee Health Care Access Act; providing that a small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan; requiring carriers to separate the experience of

grandfathered health plans and nongrandfathered health plans for determining rates; amending s. 641.31, F.S.; providing that nongrandfathered health plans are not subject to rate review or approval by the office; providing for future repeal; amending s. 627.6675, F.S.; specifying conditions for nonrenewal of a converted policy; amending s. 641.3922, F.S.; specifying conditions for nonrenewal of a health maintenance organization converted contract; authorizing positions and providing an appropriation; providing effective dates.

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

Section 1. Section 624.25, Florida Statutes, is created to read:

624.25 Florida Insurance Code; applicability with respect to Patient Protection and Affordable Care Act.—A provision of the Florida Insurance Code, or any rule adopted pursuant to the code, applies unless such provision or rule prevents the application of a provision of PPACA. As used in this section, the term "PPACA" has the same meaning as provided in s. 627.402.

Section 2. Section 624.26, Florida Statutes, is created to read:

624.26 Collaborative arrangement with the United States Department of Health and Human Services.—

(1) As used in this section, the term "PPACA" has the same meaning as provided in s. 627.402.

(2) When reviewing forms filed by health insurers or health maintenance organizations pursuant to s. 627.410 or s. 641.31(3) for compliance with state law, the office may also review such forms for compliance with PPACA. If the office determines that the form does not comply with PPACA, the office shall inform the insurer or organization of the reason for noncompliance. If the office determines that a form ultimately used by an insurer or organization does not comply with PPACA, the office may report such potential violation to the United States Department of Health and Human Services. The review of forms by the office under this subsection does not include review of the rates, rating practices, or the relationship of benefits to the rates.

(3) When performing market conduct examinations or investigations of health insurers or health maintenance organizations as authorized under s. 624.307, s. 624.3161, or s. 641.3905 for compliance with state law, the office may include compliance with PPACA within the scope of such examination or investigation. If the office determines that an insurer's or organization's operations do not comply with PPACA, the office shall inform the insurer or organization of the reason for such determination. If the insurer or organization does not take action to comply with PPACA, the office may report such potential violation to the United States Department of Health and Human Services.

(4) The department's Division of Consumer Services may respond to complaints by consumers relating to a requirement of PPACA as authorized under s. 20.121(2)(h) and report apparent or

potential violations to the office and to the United States Department of Health and Human Services.

(5) A determination made by the office or department pursuant to this section regarding compliance with PPACA does not constitute a determination that affects the substantial interests of any party for purposes of chapter 120.

Section 3. Subsection (2) of section 624.34, Florida Statutes, is amended to read:

624.34 Authority of Department of Law Enforcement to accept fingerprints of, and exchange criminal history records with respect to, certain persons.—

(2) The Department of Law Enforcement may accept fingerprints of individuals who apply for a license as an agent, customer representative, adjuster, service representative, navigator, or managing general agent or the fingerprints of the majority owner, sole proprietor, partners, officers, and directors of a corporation or other legal entity that applies for licensure with the department or office under ~~the provisions of~~ the Florida Insurance Code.

Section 4. Part XII of chapter 626, Florida Statutes, consisting of ss. 626.995-626.9958, is created to read:

PART XII

NAVIGATORS

626.995 Scope of part.-This part applies only to navigators.

626.9951 Definitions.-As used in this part, the term:

(1) "Exchange" means an exchange established for this state under PPACA.

(2) "Financial services business" means a financial activity regulated by the Department of Financial Services, the Office of Insurance Regulation, or the Office of Financial Regulation.

(3) "Navigator" means 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, pursuant to 42 U.S.C. s. 18031(i)(1), who facilitates the selection of a qualified health plan through the exchange and performs any other duties specified under 42 U.S.C. s. 18031(i)(3).

(4) "PPACA" has the same meaning as in s. 627.402.

626.9952 Registration required; purpose.-

(1) Beginning August 1, 2013, an individual may not act as, offer to act as, or advertise any service as a navigator unless registered with the department under this part.

(2) The purpose of registration is to identify qualified individuals to assist the insurance-buying public in selecting a qualified health plan through an exchange by providing fair, accurate, and impartial information regarding qualified health plans and the availability of premium tax credits and cost-sharing reductions for such plans, and to protect the public from unauthorized activities or conduct.

626.9953 Qualifications for registration; application required.-

(1) The department may not approve the registration of an individual as a navigator who is found by the department to be untrustworthy or incompetent, and who does not meet the

following requirements:

(a) Is a natural person at least 18 years of age.

(b) Is a United States citizen or legal alien who possesses work authorization from the United States Bureau of Citizenship and Immigration Services.

(c) Has successfully completed all training for a navigator as required by the federal government or the exchange.

(2) To be registered as a navigator, an applicant must submit a sworn, signed, written application to the department on a form prescribed by the department, meet the qualifications for registration as a navigator, and make payment in advance of all applicable fees. Individuals previously disqualified must apply for reinstatement using the same procedures required for initial registration.

(3) The applicant must set forth all of the following information in the application:

(a) His or her full name, age, social security number, residence address, business address, mailing address, contact telephone numbers, including a business telephone number if applicable, and e-mail address.

(b) Whether he or she has been refused a financial services license or has voluntarily surrendered or has had his or her financial services license suspended or revoked in this or any other state.

(c) His or her native language.

(d) His or her highest level of education.

(e) A statement of acknowledgement of conduct that is prohibited under this part and the penalties associated with

such conduct.

(f) Certification that the training required by the federal government or the exchange has been successfully completed.

(g) Such additional information as the department may deem proper to enable it to determine the character, experience, ability, and other qualifications of the applicant to participate as a registered navigator.

(4) Each application must be accompanied by payment of a nonrefundable $50 application filing fee to be deposited in the Insurance Regulatory Trust Fund.

(5) An applicant must submit a set of his or her fingerprints to the department and pay the processing fee established under s. 624.501(24). The department shall submit the applicants' fingerprints to the Department of Law Enforcement for processing state criminal history records checks and local criminal records checks through local law enforcement agencies and for forwarding to the Federal Bureau of Investigation for national criminal history records checks. The fingerprints shall be taken by a law enforcement agency, a designated examination center, or another department-approved entity. The department may not approve an application for registration as a navigator if fingerprints have not been submitted.

(6) In addition to information requested in the application, the department may propound any reasonable interrogatories to an applicant relating to the applicant's qualifications, residence, prospective place of business, and

any other matters that, in the opinion of the department, are deemed necessary or advisable for the protection of the public and to ascertain the applicant's qualifications. In addition to the submission of fingerprints for criminal background screening, the department may make such further investigations as it may deem advisable of the applicant's character, experience, background, and fitness for registration as specified under this part.

(7) Pursuant to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, an applicant must provide his or her social security number in accordance with subsection (3) for the purpose of administering the Title IV-D program for child support enforcement.

626.9954 Disqualification from registration.—

(1) As used in this section, the terms "felony of the first degree" and "capital felony" include all felonies so designated by the laws of this state, as well as any felony so designated in the jurisdiction in which the plea is entered or judgment is rendered.

(2) An applicant who commits a felony of the first degree; a capital felony; a felony involving money laundering, fraud, or embezzlement; or a felony directly related to the financial services business is permanently barred from applying for registration under this part. This bar applies to convictions, guilty pleas, or nolo contendere pleas, regardless of adjudication, by an applicant.

(3) For all other crimes not described in subsection (2), the department may adopt rules establishing the process and

application of disqualifying periods including:

(a) A 15-year disqualifying period for all felonies involving moral turpitude which are not specifically included in subsection (2).

(b) A 7-year disqualifying period for all felonies not specifically included in subsection (2) or paragraph (a).

(c) A 7-year disqualifying period for all misdemeanors directly related to the financial services business.

(4) The department may adopt rules providing additional disqualifying periods due to the commitment of multiple crimes and other factors reasonably related to the applicant's criminal history. The rules must provide for mitigating and aggravating factors. However, mitigation may not result in a disqualifying period of less than 7 years and may not mitigate the disqualifying periods in paragraph (3)(b) or paragraph (3)(c).

(5) For purposes of this section, the disqualifying periods begin upon the applicant's final release from supervision or upon completion of the applicant's criminal sentence, including the payment of fines, restitution, and court costs for the crime for which the disqualifying period applies.

(6) After the disqualifying period has been met, the burden is on the applicant to demonstrate to the satisfaction of the department that he or she has been rehabilitated and does not pose a risk to the insurance-buying public and is otherwise qualified for registration.

(7) Section 112.011 does not apply to an applicant for registration as a navigator.

626.9955 Registered navigator list.—Upon approval of an

application for registration under this part, the department shall add the name of the registrant to its publicly available list of registered navigators in order for operators of an exchange and other interested parties to validate a navigator's registration.

626.9956 Notice of change of registrant information.—A navigator must notify the department, in writing, within 30 days after a change of name, residence address, principal business street address, mailing address, contact telephone number, including a business telephone number, or e-mail address. Failure to notify the department within the required time is subject to a fine of up to $250 for the first offense, and a fine of at least $500 or suspension or revocation for a subsequent offense. The department may adopt rules to administer and enforce this section.

626.9957 Conduct prohibited; denial, revocation, or suspension of registration.—

(1) As provided in s. 626.112, only a person licensed as an insurance agent or customer representative may engage in the solicitation of insurance. A person who engages in the solicitation of insurance as described in s. 626.112(1) without such license is subject to the penalties provided under s. 626.112(9).

(2) Whether licensed by the department as an agent or customer representative, a navigator may not perform any of the following while acting as a navigator:

(a) Solicit, negotiate, or sell health insurance; or

(b) Recommend the purchase of a particular health plan or

represent one health plan as preferable over another.

(3) A navigator may not:

(a) Recommend the purchase, assist with enrollment, or provide services related to health benefit plans or products not offered through the exchange other than providing information about Medicaid and the Children's Health Insurance Program (CHIP);

(b) Recommend or assist with the cancellation of insurance coverage purchased outside the exchange; or

(c) Receive compensation or anything of value from an insurer, health plan, business, or consumer in connection with performing the activities of a navigator, other than from the exchange or an entity or individual who has received a navigator grant pursuant to 45 C.F.R. s. 155.210.

(4) The department may deny an application for registration as a navigator or suspend or revoke the registration of a navigator if it finds that any one or more of the following grounds exist:

(a) Violation of this part or any applicable provision of this chapter.

(b) Violation of department order or rule.

(c) Having 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 PPACA.

(d) Lack one or more of the qualifications required under this part.

(e) Material misstatement, misrepresentation, or fraud in obtaining or attempting to obtain registration under this part.

(f) Any cause for which issuance of the registration could have been refused if it had existed and been known to the department.

(g) Having been found guilty or having pled guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 or more years under the law of the United States or any state thereof or under the law of any country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

(h) Failure to inform the department in writing within 30 days after pleading guilty or nolo contendere to, or being convicted or found guilty of, any felony or crime punishable by imprisonment of 1 or more years under the law of the United States or of any state thereof, or under the law of any other country without regard to whether a judgment of conviction has been entered by the court having jurisdiction of the case.

(i) Violating or knowingly aiding, assisting, procuring, advising, or abetting another in violating the insurance code or any order or rule of the department, commission, or office.

(j) Failure to comply with any civil, criminal, or administrative action taken by the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. ss. 651 et seq., to determine paternity or to establish, modify, enforce, or collect support.

(5) If the department finds that one or more grounds exist for the suspension or revocation of a navigator's registration, the department may, in lieu of or in addition to suspension or revocation, impose upon the registrant an administrative penalty

of up to $500, or if the department finds willful misconduct or a willful violation, an administrative penalty of up to $3,500.

(6) A person who acts as a navigator without being registered under this part is subject to an administrative penalty of up to $1,500.

(7)(a) Pursuant to s. 120.569, the department may issue a cease and desist order or an immediate final order to cease and desist to any person who violates this section.

(b) A person who violates, or assists in the violation of, an order of the department while such order is in effect is, at the discretion of the department, subject to:

1. A monetary penalty of up to $50,000; or

2. Suspension or revocation of such person's registration.

(8) If a navigator registered under this part enters a plea of guilty or nolo contendere, or is convicted by a court of a violation of this code or a felony, the registration of such individual shall be immediately revoked by the department. The individual may subsequently request a hearing pursuant to ss. 120.569 and 120.57, which shall be expedited by the department. The sole issue at the hearing shall be whether the revocation of registration should be rescinded because such individual was not in fact convicted of a violation of this code or a felony.

(9) An order by the department suspending the registration of a navigator must specify the period during which the suspension is to be in effect, which may not exceed 2 years. The registration shall remain suspended during the period specified, subject to rescission or modification of the order by the department, or modification or reversal by the court, before

expiration of the suspension period. A registration that has been suspended may not be reinstated except upon the filing and approval of an application for reinstatement; however, the department may not approve an application for reinstatement if it finds that the circumstance or circumstances for which the registration was suspended still exist or are likely to recur. An application for reinstatement is also subject to disqualification and waiting periods before approval on the same grounds that apply to applications for registration under s. 626.9954.

(10) An individual whose registration has been revoked may not apply for registration as a navigator until 2 years after the effective date of such revocation or, if judicial review of such revocation is sought, within 2 years after the date of the final court order or decree affirming the revocation.

(11) Revocation or suspension of the registration of a navigator under this part shall be immediately reported by the department to the operator of the exchange. An individual whose registration has been revoked or suspended may not act as, offer to act as, or advertise any service as a navigator until the department reinstates such registration.

(12) The department may adopt rules establishing specific penalties against registrants in accordance with this section. The purpose of revocation or suspension is to provide a sufficient penalty to deter behavior incompatible with the public health, safety, and welfare. The imposition of a revocation or the duration of a suspension shall be based on the type of conduct and the likelihood that the propensity to commit

further illegal conduct has been overcome at the time of eligibility for reinstatement. The length of suspension may be adjusted based on aggravating or mitigating factors established by rule and consistent with this purpose.

626.9958 Rulemaking.—The department may adopt rules to administer this part.

Section 5. Section 627.402, Florida Statutes, is amended to read:

627.402 Definitions~~; specified certificates not included~~.—As used in this part, the term:

(1) "Grandfathered health plan" has the same meaning as provided in 42 U.S.C. s. 18011, subject to the conditions for maintaining status as a grandfathered health plan specified in regulations adopted by the United States Department of Health and Human Services in 45 C.F.R. s. 147.140.

(2) "Nongrandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified in s. 627.6561(5)(b)-(e).

(3)~~(1)~~ "Policy" means a written contract of insurance or written agreement for or effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements, and papers that ~~which~~ are a part thereof.

~~(2)~~ The term ~~word~~ "certificate" as used in this subsection ~~section~~ does not include certificates as to group life or health insurance or as to group annuities issued to individual insureds.

(4) "PPACA" means the Patient Protection and Affordable

Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to those federal acts.

Section 6. Subsection (2) of section 627.410, Florida Statutes, is republished, subsection (6) of that section is amended, subsection (7) of that section is republished, and subsection (9) is added to that section, to read:

627.410 Filing, approval of forms.—

(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This

paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is ~~shall~~ not ~~be~~ considered to be available for purchase unless the insurer has actively offered it for sale during ~~in~~ the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing ~~its decision~~ at least 30 days before ~~prior to~~ discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or certificate form for sale in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may ~~shall~~ not file for approval a new policy form providing ~~similar~~ benefits similar to ~~as~~ the discontinued form for ~~a period of~~ 5 years after the 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 due to noncompliance 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 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, 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.

(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 promulgated by the commission.

2. If no rate change is proposed, a filing 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.

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its

conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

(9) For plan years 2014 and 2015, nongrandfathered health plans for the individual or small group market are not subject to rate review or approval by the office. An insurer or health maintenance organization issuing or renewing such health plans shall file rates and any change in rates with the office as required by paragraph (6)(a), but the filing and rates are not subject to subsection (2), paragraphs (6)(b)-(d), or subsection (7).

(a) For each individual and small group nongrandfathered health plan, an insurer or health maintenance organization shall include a notice describing or illustrating the estimated impact of PPACA on monthly premiums with the delivery of the policy or contract or, upon renewal, the premium renewal notice. The notice shall be in a format established by rule of the

commission. All notices shall be submitted to the office for informational purposes by September 1, 2013. The notice is required only for the first issuance or renewal of the policy or contract on or after January 1, 2014.

(b) The notice shall be based on the statewide average premium for the policy or contract form for the bronze-level, silver-level, gold-level, or platinum-level plan, whichever is applicable to the policy or contract, and shall estimate the following effects of PPACA requirements:

1. The dollar amount of the premium that is due to the impact of guaranteed issuance of coverage. This estimate must include, but not necessarily itemize, the impact of the requirement that rates may not be based on any health status-related factors, how the individual coverage mandate and subsidies provided in the health insurance exchange established in this state pursuant to PPACA affect the impact of guaranteed issuance of coverage, and estimated reinsurance credits.

2. The dollar amount of the premium that is due to fees, taxes, and assessments.

3. For individual policies or contracts, the dollar amount of the premium increase or decrease, from what the premium would have otherwise been, due to the combined impact of the requirement that rates for age be limited to a 3-to-1 ratio and the prohibition against using gender as a rating factor. This estimate must be displayed for the average rates for male and female insureds, respectively, for the following three age categories: age 21 years to 29 years, age 30 years to 54 years, and age 55 years to 64 years.

4. The dollar amount due to the requirement to provide essential health benefits and to meet the required actuarial value for the product, as compared to the statewide average premium for the policy or contract for the plan issued by that insurer or organization that has the highest enrollment in the individual or small group market on July 1, 2013, whichever is applicable. The statewide average premiums for the plan with the highest enrollment must include all policyholders, including those policyholders with health conditions that increase the standard premium.

(c) The office, in consultation with the department, shall develop a summary of the estimated impact of PPACA on monthly premiums as contained in the notices submitted by insurers and health maintenance organizations, which must be available on the respective websites of the office and department by October 1, 2013.

(d) This subsection is repealed March 1, 2015.

Section 7. Subsection (4) is added to section 627.411, Florida Statutes, to read:

627.411 Grounds for disapproval.—

(4) The provisions of this section that apply to rates, rating practices, or the relationship of benefits to the premium charged do not apply to nongrandfathered health plans described in s. 627.410(9). This subsection is repealed March 1, 2015.

Section 8. Subsection (3) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(3) In addition to the outline of coverage, a policy as

specified in s. 627.6699(3)(l) ~~627.6699(3)(k)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or the name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the United States ~~federal~~ Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided

through other electronic technology.

Section 9. Paragraph (a) of subsection (3) of section 627.6425, Florida Statutes, is amended to read:

627.6425 Renewability of individual coverage.—

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

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

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

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

have the same meaning as provided in s. 627.402.

Section 10. Section 627.6484, Florida Statutes, is amended to read:

627.6484 Dissolution of association; termination of enrollment; availability of other coverage.—

(1) The association shall accept applications for insurance only until June 30, 1991, after which date no further applications may be accepted.

(2) Coverage for each policyholder of the association shall terminate at midnight on June 30, 2014, or on the date that health insurance coverage is effective with another insurer, whichever occurs first, and such coverage may not be renewed.

(3) The association must provide assistance to each policyholder concerning how to obtain health insurance coverage. Such assistance shall include the identification of insurers and health maintenance organizations offering coverage in the individual market, including inside and outside of the health insurance exchange established in this state pursuant to PPACA as defined in s. 627.402, a basic explanation of the levels of coverage available, and specific information relating to local and online sources where each policyholder may obtain detailed policy and premium comparisons and directly obtain coverage.

(4) The association shall provide written notice to all policyholders by September 1, 2013, that informs each policyholder with respect to:

(a) The date that coverage with the association is terminated and that such coverage may not be renewed.

(b) The opportunity for the policyholder to obtain individual health insurance coverage on a guaranteed-issue basis, regardless of the policyholder's health status, from any health insurer or health maintenance organization that offers coverage in the individual market, including the dates of open enrollment periods for obtaining such coverage.

(c) How to access coverage through the health insurance exchange and the potential for obtaining reduced premiums and cost-sharing provisions depending on the policyholder's family income level.

(d) Contact information for a representative of the association who is able to provide additional information about obtaining individual health insurance coverage both inside and outside of the health insurance exchange.

(5) After termination of coverage, the association must continue to receive and process timely submitted claims in accordance with the laws of this state.

(6) By March 15, 2015, the association must determine the final assessment to be collected from insurers for funding claims and administrative expenses of the association or, if surplus funds remain, determine the refund amount to be provided to each insurer based on the same pro rata formula used for determining each insurer's assessment.

(7) By September 1, 2015, the board must:

(a) Complete performance of all program responsibilities.

(b) Sell or otherwise dispose of all physical assets of the association.

(c) Make a final accounting of the finances of the

association.

(d) Transfer all records to the Department of Financial Services, which shall serve as custodian of such records.

(e) Execute a legal dissolution of the association and report such action to the Chief Financial Officer, the Insurance Commissioner, the President of the Senate, and the Speaker of the House of Representatives.

(f) Transfer any remaining funds of the association to the Chief Financial Officer for deposit in the General Revenue Fund.

~~Upon receipt of an application for insurance, the association shall issue coverage for an eligible applicant. When appropriate, the administrator shall forward a copy of the application to a market assistance plan created by the office, which shall conduct a diligent search of the private marketplace for a carrier willing to accept the application.~~

~~(2) The office shall, after consultation with the health insurers licensed in this state, adopt a market assistance plan to assist in the placement of risks of Florida Comprehensive Health Association applicants. All health insurers and health maintenance organizations licensed in this state shall participate in the plan.~~

~~(3) Guidelines for the use of such program shall be a part of the association's plan of operation. The guidelines shall describe which types of applications are to be exempt from submission to the market assistance plan. An exemption shall be based upon a determination that due to a specific health condition an applicant is ineligible for coverage in the standard market. The guidelines shall also describe how the~~

~~market assistance plan is to be conducted, and how the periodic reviews to depopulate the association are to be conducted.~~

~~(4) If a carrier is found through the market assistance plan, the individual shall apply to that company. If the individual's application is accepted, association coverage shall terminate upon the effective date of the coverage with the private carrier. For the purpose of applying a preexisting condition limitation or exclusion, any carrier accepting a risk pursuant to this section shall provide coverage as if it began on the date coverage was effectuated on behalf of the association, and shall be indemnified by the association for claims costs incurred as a result of utilizing such effective date.~~

~~(5) The association shall establish a policyholder assistance program by July 1, 1991, to assist in placing eligible policyholders in other coverage programs, including Medicare and Medicaid.~~

Section 11. Section 627.64872, Florida Statutes, is repealed.

Section 12. Effective October 1, 2015, sections 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, Florida Statutes, are repealed.

Section 13. Subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s. 627.6699(3)(l) ~~627.6699(3)(k)~~ must be accompanied by an identification card

that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the United States ~~federal~~ Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 14. Paragraph (a) of subsection (3) of section

627.6571, Florida Statutes, is amended to read:

627.6571 Guaranteed renewability of coverage.—

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

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

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

3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to the claims experience of those policyholders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage. If a policy form covers both grandfathered and nongrandfathered health plans, an insurer may nonrenew coverage only for nongrandfathered health plans, in which case the requirements of subparagraphs 1. and 2. apply only to the nongrandfathered health plans. As used in this subparagraph, the terms "grandfathered health plan" and "nongrandfathered health plan" have the same meanings as

provided in s. 627.402.

Section 15. Paragraphs (j) through (w) of subsection (3) of section 627.6699, Florida Statutes, are redesignated as paragraphs (k) through (x), respectively, a new paragraph (j) is added to that subsection, present paragraphs (v) and (w) of that subsection are amended, and paragraph (b) of subsection (6) is amended, to read:

627.6699 Employee Health Care Access Act.—

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

(j) "Grandfathered health plan" and "nongrandfathered health plan" have the same meanings as provided in s. 627.402.

(w) ~~(v)~~ "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year:

1. For a grandfathered health plan, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of ~~eligible~~ employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the

conditions and criteria established in this section are met.

2. For a nongrandfathered health plan, any employer that has its principal place of business in this state, employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. As used in this subparagraph, the terms "employee" and "employer" have the same meanings as provided in s. 3 of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. s. 1002.

(x) ~~(w)~~ "Small employer carrier" means a carrier that offers health benefit plans covering ~~eligible~~ employees of one or more small employers.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is ~~must be~~ determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family

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

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the ~~prior to~~ 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

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

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

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. ~~Nothing in~~ This subparagraph does not exempt

~~exempts~~ an alliance or group association from licensure for ~~any~~ activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to ~~not to exceed~~ 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the commission, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the

current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning within ~~not more than~~ 60 days after the report is sent to the office. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

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

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

employer.

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

a.~~b.~~ If a carrier separates the experience of small employer groups ~~as provided in sub-subparagraph a.~~, the rate to be charged to small employer groups of fewer ~~less~~ than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

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

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

Section 16. Paragraph (f) is added to subsection (3) of

section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(3)

(f)1. For plan years 2014 and 2015, nongrandfathered health plans for the individual or small group market are not subject to rate review or approval by the office. A health maintenance organization that issues or renews a nongrandfathered health plan is subject to s. 627.410(9). As used in this paragraph, the terms "PPACA" and "nongrandfathered health plan" have the same meanings as provided in s. 627.402.

2. This paragraph is repealed March 1, 2015.

Section 17. Subsections (6) and (7) of section 627.6675, Florida Statutes, are amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance,

referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(6) OPTIONAL COVERAGE.—The insurer shall not be required to issue a converted policy covering any person who is or could be covered by Medicare. The insurer shall not be required to issue or renew a converted policy covering a person if paragraphs (a) and (b) apply to the person:

(a) If any of the following apply to the person:

1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program.

2. The person is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

3. Similar benefits are provided for or are available to the person under any state or federal law.

(b) If the benefits provided under the sources referred to

in subparagraph (a)1. or the benefits provided or available under the sources referred to in subparagraphs (a)2. and 3., together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the office prior to their use in denying coverage.

(7) INFORMATION REQUESTED BY INSURER.—

(a) A converted policy may include a provision under which the insurer may request information, in advance of any premium due date, of any person covered thereunder as to whether:

1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.

2. The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

3. Similar benefits are provided for or are available to the person under any state or federal law.

(b) The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person only for one or more of the following reasons:

1. Either the benefits provided under the sources referred to in subparagraphs (a)1. and 2. for the person or the benefits provided or available under the sources referred to in

subparagraph (a)3. for the person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the office. The reason for nonrenewal authorized by this subparagraph 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.

2. The converted policyholder fails to provide the information requested pursuant to paragraph (a).

3. Fraud or intentional misrepresentation in applying for any benefits under the converted policy.

4. Other reasons approved by the office.

Section 18. Subsection (6) of section 641.3922, Florida Statutes, is amended, and paragraph (h) is added to subsection (7) of that section, to read:

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

(6) OPTIONAL COVERAGE.—The health maintenance organization shall not be required to issue a converted contract covering any person if such person is or could be covered by Medicare, Title XVIII of the Social Security Act, as added by the Social Security Amendments of 1965, or as later amended or superseded. Furthermore, the health maintenance organization shall not be required to issue or renew a converted health maintenance contract covering any person if:

(a)1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber

contract or medical practice or other prepayment plan or by any other plan or program;

2. The person is eligible for similar benefits, whether or not covered therefor, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

3. Similar benefits are provided for or are available to the person pursuant to or in accordance with the requirements of any state or federal law; and

(b) A converted health maintenance contract may include a provision whereby the health maintenance organization may request information, in advance of any premium due date of a health maintenance contract, of any person covered thereunder as to whether:

1. She or he is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

2. She or he is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

3. Similar benefits are provided for or are available to the person pursuant to or in accordance with the requirements of any state or federal law.

(7) REASONS FOR CANCELLATION; TERMINATION.—The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance

organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(h) The subscriber is covered for similar benefits, the subscriber is eligible for similar benefits, or similar benefits are provided for or are available to the subscriber as described in paragraph (6)(a). The reason for nonrenewal authorized by this paragraph is not required to be contained in the converted health maintenance contract but must be provided in writing to the subscriber at least 90 days before the contract renewal date.

Section 19. Two full-time equivalent positions, with associated salary rate of 72,936, are authorized and the sums of $106,658 in recurring funds and $70,000 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund to the Department of Financial Services for the 2013-2014 fiscal year to implement the provisions of part XII of chapter 626, Florida Statutes, as created by this act, relating to the registration of navigators.

Section 20. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.