**By** Senator Soto

14-01193B-15 20151498__

A bill to be entitled

An act relating to health insurance exchanges; providing a short title; creating s. 641.81, F.S.; providing legislative findings and intent; defining terms; requiring the Agency for Health Care Administration to establish the Florida Health Access Marketplace; requiring the agency to establish the Small Business Health Options Program (SHOP); providing contracting and rulemaking authority; authorizing the marketplace to contract with certain entities; defining "eligible entity"; authorizing the agency to adopt rules; providing for information sharing and confidentiality; providing for insurance coverage availability; providing for the responsibilities and duties of the marketplace; providing for health benefit plan certification; requiring the marketplace to certify certain health benefit plans; providing a contingent effective date.

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

Section 1. This act may be cited as the "Florida Health Access Marketplace Act".

Section 2. Section 641.81, Florida Statutes, is created to read:

641.81 Florida Health Access Marketplace.—

(1) INTENT.—The Legislature finds that a historically significant proportion of the residents of this state have been unable to obtain affordable health insurance coverage. The

Legislature also finds that increasing access to affordable, quality health care is beneficial to the health and well-being of all of the state's residents, is necessary for the state's economic vitality, and provides a substantial boost to the business activity of the state. The Legislature recognizes that more than 1.6 million hardworking residents of this state purchased health insurance for 2015 on the Affordable Care Act federal health insurance exchange. The Legislature also recognizes that 93 percent, or nearly all, of those residents received tax credits that averaged $297 per person each month. The Legislature finds that the United States Supreme Court is scheduled to render a decision that may affect the availability of those tax credits to residents of this state after the end of Florida's 2015 Regular Session. The Legislature also finds that the Court may decide that only those individuals who buy health insurance policies on state-based exchanges are eligible for the federal tax credits. The Legislature recognizes that should the Court issue such a ruling, more than 1 million residents of this state could be at substantial risk of losing their access to affordable health care and the economy of this state may lose an estimated $4.75 billion in subsidy spending, when the loss of both premium tax credits and cost-sharing assistance are considered. Therefore, in order to preserve the ability of residents of this state to qualify for the federal tax credits and in order to keep those tax credits operative in the state's economy and available to residents of this state in need of affordable health insurance, it is the intent of the Legislature, contingent upon a ruling by the United States Supreme Court that only state-based exchange policy purchasers

are eligible for federal tax credits and subsidies, to establish a state-based health insurance exchange, pursuant to s. 1311 of the Affordable Care Act.

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

(a) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

(b) "Agency" means the Agency for Health Care Administration.

(c) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term "health benefit plan" does not include:

1. Coverage only for accident or disability income insurance or any combination of accident or disability income insurance.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for on-site medical clinics.

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

9. The following benefits, if they are provided under a

separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

a. Limited scope dental or vision benefits.

b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits.

c. Limited benefits as specified in federal regulations issued pursuant to the federal HIPAA of 1996.

d. Coverage only for a specified disease or illness.

e. Hospital indemnity or other fixed indemnity insurance.

f. Medicare supplemental health insurance policies as defined under the Social Security Act, 42 U.S.C. s. 1882(g)(1), whether provided individually or under a group health plan.

g. Coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, whether provided individually or under a group health plan.

(d) "Health carrier" or "carrier" means:

1. An insurance company licensed in accordance with the Florida Insurance Code to provide health insurance.

2. A health maintenance organization licensed pursuant to the Florida Insurance Code.

3. A preferred provider administrator registered under the Florida Insurance Code.

4. A nonprofit hospital or medical service organization or health benefit plan licensed pursuant to Title XXIX or the Florida Insurance Code.

(e) "Marketplace" means the Florida Health Access Marketplace established in this section pursuant to s. 1311 of the Affordable Care Act.

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

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

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

(g) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in this section and s. 1311(c) of the Affordable Care Act.

(h) "Qualified individual" means an individual, including a minor, who:

1. Is seeking to enroll in a qualified health plan or qualified stand-alone dental benefit plan offered to individuals through the marketplace;

2. Resides in this state within the meaning of the Affordable Care Act;

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

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

(i) "Qualified stand-alone dental benefit plan" means a

stand-alone dental benefit plan that has been certified in accordance with subsection (8).

(j) "SHOP exchange" means the Small Business Health Options Program established pursuant to subsection (3).

(k) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year. For purposes of this paragraph:

1. All persons treated as a single employer under the Internal Revenue Code, 26 U.S.C. s. 414(b), (c), (m) or (o), must be treated as a single employer.

2. A successor employer and a predecessor employer, under the Internal Revenue Code, 26 U.S.C. s. 414, must be treated as a single employer.

3. All employees must be counted, including part-time employees and employees who are not eligible for coverage through the employer.

4. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees reasonably expected to be employed by that employer on business days in the current calendar year.

5. An employer that makes enrollment in qualified health plans or qualified stand-alone dental benefit plans available to its employees through the SHOP exchange, and, in a subsequent calendar year, would cease to be a small employer by reason of an increase in the number of its employees, must continue to be treated as a small employer for purposes of this section as long as the employer continuously makes enrollment through the SHOP exchange available to its employees.

(l) "Stand-alone dental benefit plan" means a policy, contract, certificate, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of limited scope dental benefits meeting the requirements of s. 9832(c)(2)(A) of the Internal Revenue Code of 1986.

(3) MARKETPLACE ESTABLISHED; PURPOSES.—The agency shall establish the Florida Health Access Marketplace to function as a health insurance exchange, pursuant to the Affordable Care Act, to facilitate the purchase and sale of qualified health plans and qualified stand-alone dental benefit plans in the individual market in this state and to provide for the establishment of a Small Business Health Options Program to assist qualified employers in this state in facilitating the enrollment of their employees in qualified health plans and qualified stand-alone dental benefit plans offered in the small group market. The purpose of the marketplace is to reduce the number of uninsured individuals, provide a transparent marketplace and consumer education, and assist individuals with access to programs, premium tax credits, and cost-sharing reductions. It is also the purpose of the marketplace to maximize the receipt of federal funds, including those available pursuant to the Affordable Care Act.

(4) CONTRACTING AND RULEMAKING AUTHORITY.—The marketplace may contract with an eligible entity for any of its functions as described in this section. For the purposes of this subsection, "eligible entity" includes, but is not limited to, any program or entity, public or private, that has experience in individual and small group health insurance or benefit administration or

other experience relevant to the services needed to carry out the purposes of this section, except that a health carrier or the affiliate of a health carrier is not an eligible entity. The agency may adopt rules as necessary for the proper administration and enforcement of this section under the Florida Administrative Procedure Act.

(5) INFORMATION SHARING; CONFIDENTIALITY.—The marketplace may enter into information-sharing agreements with federal and state agencies and other states' exchanges to carry out its responsibilities under this section. Such agreements must include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules and regulations.

(6) AVAILABILITY OF COVERAGE.—

(a) The marketplace shall make qualified health plans and qualified stand-alone dental benefit plans available to qualified individuals and qualified employers no later than January 1, 2017. The marketplace may enroll qualified individuals and qualified employers beginning on or after September 1, 2016.

(b) The marketplace may not make available any health benefit plan that is not a qualified health plan or any stand-alone dental benefit plan that is not a qualified stand-alone dental benefit plan.

(c) The marketplace shall allow a health carrier to offer a qualified stand-alone dental benefit plan through the marketplace, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of s. 1302(b)(1)(J) of the

Affordable Care Act. This paragraph does not prohibit a carrier from offering other dental benefit plans consistent with the requirements of subsection (8) of this section.

(d) The marketplace or a carrier offering qualified health plans or qualified stand-alone dental benefit plans through the marketplace may not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of s. 1401 of the Affordable Care Act.

(e) The agency may standardize qualified health plans to be offered through the marketplace.

(7) DUTIES AND RESPONSIBILITIES OF THE MARKETPLACE.—The marketplace shall:

(a) Implement procedures, consistent with guidelines developed under this section and s. 1311(c) of the Affordable Care Act, for the certification, recertification, and decertification of health benefit plans as qualified health plans and of stand-alone dental benefit plans as qualified stand-alone dental benefit plans.

(b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, which includes the opportunity for live customer service.

(c) Make available enrollment periods as provided under s. 1311(c)(6) of the Affordable Care Act.

(d) Maintain a publicly accessible website through which enrollees and prospective enrollees of qualified health plans and qualified stand-alone dental benefit plans may obtain

standardized comparative information on such plans.

(e) Assign a rating to each qualified health plan offered through the marketplace in accordance with the rating system developed under s. 1311(c)(3) of the Affordable Care Act and determine each qualified health plan's level of coverage in accordance with regulations issued under s. 1302(d)(2)(A) of the Affordable Care Act.

(f) Use a standardized format for presenting health and dental benefit options in the marketplace, including the use of the uniform outline of coverage established under the Public Health Service Act, 42 U.S.C. s. 300gg-15 (2010).

(g) In accordance with s. 1413 of the Affordable Care Act, inform individuals of eligibility requirements for the Medicaid program under Title XIX of the United States Social Security Act, the State Children's Health Insurance Program under Title XXI of the United States Social Security Act, or under any applicable state or local public program and if, through screening of an application by the marketplace, the marketplace determines that an individual is eligible for any such program, enroll the individual in that program.

(h) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the marketplace and coordinate that process with the state and local government entities administering other health care coverage programs, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages. To the extent possible, the agency shall encourage the use of existing infrastructure and capacity from other state agencies.

(i) Determine the minimum requirements a carrier must meet to be considered for participation in the marketplace and the standards and criteria for selecting qualified health plans to be offered through the marketplace which are in the best interests of qualified individuals and qualified employers. The agency shall consistently and uniformly apply these requirements, standards, and criteria to all carriers offering qualified health plans through the marketplace and, if relevant, shall apply those requirements, standards, and criteria to carriers offering qualified stand-alone dental benefit plans or other dental benefit plans through the marketplace. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified employers through the marketplace, the agency shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality and service. In its evaluation of the quality of health care coverage offered by a carrier, the agency shall consider comparative health care quality information and assessments.

(j) Provide, in each region of the state, a choice of qualified health plans at each of the levels of coverage contained in s. 1302(d) and (e) of the Affordable Care Act.

(k) Require, as a condition of participation in the marketplace, carriers to fairly and affirmatively offer, market, and sell in the marketplace at least one product within each of the levels of coverage contained in s. 1302(d) and (e) of the Affordable Care Act. The agency may require carriers to offer additional products within each of the levels of coverage. This paragraph does not apply to a carrier that solely offers

supplemental coverage in the marketplace or that solely offers a qualified stand-alone dental benefit plan.

(l) Require, as a condition of participation in the marketplace, carriers selling products outside the marketplace to fairly and affirmatively offer, market, and sell all products made available to individuals and small employers in the marketplace to individuals and small employers, respectively, purchasing coverage outside the marketplace.

(m) Establish and make available by electronic means and by a toll-free telephone number a calculator to determine the actual cost of coverage after application of any premium tax credit under s. 1401 of the Affordable Care Act or any cost-sharing reduction under s. 1402 of the Affordable Care Act.

(n) Establish a SHOP exchange through which qualified employers may access coverage for their employees, enabling any qualified employer to specify a level of coverage or amount of contribution toward coverage so that any of its employees may enroll in any qualified health plan or qualified stand-alone dental benefit plan offered through the SHOP exchange at the specified level of coverage.

(o) Perform duties related to determining eligibility for premium tax credits, reduced cost sharing, and individual responsibility requirement exemptions.

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

(q) Credit the amount of any free choice voucher to the monthly premium of the health benefit plan in which an employee

is enrolled, in accordance with s. 10108 of the Affordable Care Act, and collect the amount credited from the offering qualified employer.

(r) Report on the operation of the marketplace, beginning January 1, 2018, and annually thereafter, to the Governor, the Chief Financial Officer, the President of the Senate, the Speaker of the House of Representatives, and the standing committees of the Senate and the House of Representatives having jurisdiction over appropriations and financial affairs, insurance and financial services matters, and health and human services matters. The report must include an accurate accounting of all activities, receipts and expenditures of the marketplace.

(8) HEALTH BENEFIT PLAN CERTIFICATION.—

(a) The marketplace shall certify a health benefit plan as a qualified health plan if:

1. The health benefit plan provides the essential health benefits package described in s. 1302(a) of the Affordable Care Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified stand-alone dental benefit plans, as provided in paragraph (e), if:

a. The marketplace has determined that at least one qualified stand-alone dental benefit plan is available to supplement the plan's coverage; and

b. The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the marketplace, that the plan does not provide the full range of essential pediatric dental benefits and that qualified stand-alone dental benefit plans providing those benefits and other dental benefits not covered by the plan are offered through the marketplace;

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

3. The health benefit plan provides at least a bronze level of coverage, as determined pursuant to s. 1302(d)(1)(A) of the Affordable Care Act for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;

4. The health benefit plan's cost-sharing requirements do not exceed the limits established under s. 1302(c)(1) of the Affordable Care Act and, if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under s. 1302(c)(2) of the Affordable Care Act;

5. The health carrier offering the health benefit plan:

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

b. Offers at least one qualified health plan in the silver level and at least one plan in the gold level as described in s. 1302(d)(1)(B) and (d)(1)(C) of the Affordable Care Act, respectively, through each component of the marketplace in which the carrier participates. As used in this sub-subparagraph, "component" means the SHOP exchange and the marketplace;

c. Offers at least one qualified health plan that provides the essential health benefits package described in s. 1302(a) of the Affordable Care Act without benefits that duplicate the minimum dental benefits of stand-alone dental benefit plans, if the marketplace has determined that at least one qualified stand-alone dental benefit plan is available through the marketplace to supplement the qualified health plan's coverage;

d. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the

marketplace and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

e. As required by subsection (6), does not charge any fees or penalties for termination of coverage; and

f. Complies with the regulations developed under s. 1311(c) of the Affordable Care Act and such other requirements as the marketplace may establish;

6. The health benefit plan meets the requirements of certification as adopted by agency rules and by regulations adopted under s. 1311(c) of the Affordable Care Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance; and

7. The agency determines that making the health benefit plan available through the marketplace is in the interest of qualified individuals and qualified employers.

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

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

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

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

(c) The marketplace shall require each health carrier

seeking certification of a health benefit plan as a qualified health plan to:

1. Submit a justification for any premium rate increase before implementation of that increase. The carrier shall prominently post the information concerning the justification on its publicly accessible website. The marketplace shall take this information, along with the information and the recommendations provided to the marketplace under the Public Health Service Act, 42 U.S.C. s. 300gg-94 (2010), into consideration when determining whether to allow the carrier to make health benefit plans available through the marketplace.

2. Make available to the public and submit to the marketplace accurate, transparent, and timely disclosure of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

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

h. Information on enrollee and participant rights under Title I of the Affordable Care Act.

The information required in this subparagraph must be provided in plain language, as that term is defined in s. 1311(e)(3)(B) of the Affordable Care Act.

3. Make available to an individual, in a timely manner upon

the request of the individual, the amount of cost sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through a publicly accessible website and through other means for an individual without access to the Internet.

4. Make a separate disclosure of the price of pediatric dental benefits if the plan provides a comprehensive essential health benefits package described in s. 1302(a) of the Affordable Care Act, as long as the carrier is not required to offer the pediatric dental benefit for sale on the marketplace on a stand-alone basis.

(d) The marketplace may not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements.

(e) The provisions of this section that are applicable to qualified health plans also apply to the extent relevant to qualified stand-alone dental benefit plans except as provided in this paragraph or by rules adopted by the marketplace.

1. The marketplace may certify a stand-alone dental benefit plan as a qualified stand-alone dental benefit plan if the carrier offering the plan:

a. Is licensed and in good standing to offer dental coverage in this state. The carrier need not be licensed to offer other health benefits;

b. Offers at least one stand-alone dental benefit plan that

includes only the essential pediatric dental benefit requirement of s. 1302(b)(1)(J) of the Affordable Care Act, as long as this requirement does not limit a carrier from providing other stand-alone dental benefit plans that are certified by the marketplace;

c. Charges the same premium rate for each stand-alone dental benefit plan without regard to whether the plan is offered through the marketplace and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

d. Submits the premium rates and contract language to the agency for approval;

e. As required by subsection (6), does not charge any fees or penalties for termination of coverage; and

f. Complies with any requirements adopted under s. 1311(d) of the Affordable Care Act and any rules adopted by the marketplace pursuant to this section.

2. The qualified stand-alone dental benefit plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and must meet the requirements for essential pediatric dental benefits prescribed pursuant to s. 1302(b)(1)(J) of the Affordable Care Act and such other dental benefits as may be specified by rule or regulation.

3. Carriers may jointly offer a comprehensive plan through the marketplace in which the dental benefits are provided by a carrier through a qualified stand-alone dental benefit plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also

made available for purchase separately at the same prices.

4. The marketplace may not exclude a stand-alone dental benefit plan on the basis that the plan is a fee-for-service plan or through the imposition of premium price controls by the marketplace.

(f) In addition to the certification of a qualified stand-alone dental benefit plan pursuant to this subsection, the marketplace may certify other stand-alone dental benefit plans, either as part of a qualified health plan or separately, in accordance with this subsection and any rules adopted by the marketplace.

The marketplace shall apply the criteria of this subsection in a manner that ensures fairness between or among health carriers participating in the marketplace.

Section 3. This act shall take effect October 1, 2015, if, before that date, the United States Supreme Court rules in *King v. Burwell*, Docket Number 14-114, that it is impermissible under the Patient Protection and Affordable Care Act, 42 U.S.C. s. 1321, for individuals who purchase coverage through exchanges established by the Federal Government to obtain federal tax credit subsidies or benefits or that individuals who purchase coverage through exchanges established by state governments are the only individuals eligible for federal tax credit subsidies or benefits under the Patient Protection and Affordable Care Act, 42 U.S.C. s. 1321. If the Supreme Court does not enter such a ruling before that date, or rules in *King v. Burwell* that such subsidies or benefits are available to individuals who purchase coverage through exchanges established by the Federal

Government, this act shall not take effect.