By Senator Garcia

36-01414A-26 20261354__

A bill to be entitled

An act relating to small employer health insurance; amending s. 627.6699, F.S.; deleting and revising definitions; deleting provisions relating to the creation of the Florida Small Employer Health Reinsurance Program; amending ss. 627.642, 627.6475, 627.657, and 627.66997, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraphs (b), (p), (q), and (s) of subsection (3), paragraph (d) of subsection (9), paragraphs (b) and (c) of subsection (10), and subsection (11) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

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

~~(b) "Board" means the board of directors of the program.~~

~~(p) "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board under subsection (11).~~

~~(q) "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection (11).~~

(p)~~(s)~~ "Reinsuring carrier" means a small employer carrier that elects to comply with reinsurance ~~the~~ requirements ~~set forth in subsection (11)~~.

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—

(d) A small employer carrier that elects to cease

participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan ~~under subsection (11)~~ as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans ~~under the terms set forth in subsection (11)~~ and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

(10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:

1. The carrier’s financial ability to support the assumption of the risk of small employer groups.

2. The carrier’s history of rating and underwriting small employer groups.

3. The carrier’s commitment to market fairly to all small employers in the state or its service area, as applicable.

4. The carrier’s ability to assume and manage the risk of enrolling small employer groups ~~without the protection of the reinsurance program provided in subsection (11)~~.

(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to reinsurance ~~the~~ assessment ~~provisions of subsection (11)~~.

~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.~~

~~(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."~~

~~(b)1. The program shall operate subject to the supervision and control of the board.~~

~~2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:~~

~~a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.~~

~~b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.~~

~~3. The director of the office may remove a member for cause.~~

~~4. Vacancies on the board shall be filled in the same~~

~~manner as the original appointment for the unexpired portion of the term.~~

~~(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.~~

~~2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).~~

~~3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.~~

~~(d) The plan of operation must, among other things:~~

~~1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.~~

~~2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.~~

~~3. Establish procedures for reinsuring risks.~~

~~4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.~~

~~5. Provide for any additional matters at the discretion of~~

~~the board.~~

~~(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:~~

~~1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;~~

~~2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;~~

~~3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;~~

~~4. Periodic reports by carriers and agents concerning health benefit plans issued; and~~

~~5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.~~

~~(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:~~

~~1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative~~

~~functions.~~

~~2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.~~

~~3. Take any legal action necessary to avoid the payment of improper claims against the program.~~

~~4. Issue reinsurance policies, in accordance with the requirements of this act.~~

~~5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.~~

~~6. Establish actuarial functions as appropriate for the operation of the program.~~

~~7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.~~

~~8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.~~

~~9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.~~

~~10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.~~

~~(g) A reinsuring carrier may reinsure with the program~~

~~coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:~~

~~1. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.~~

~~2. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan.~~

~~3. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.~~

~~4. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~5. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.~~

~~6. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 3., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 3. which may not be ceded to the program.~~

~~7. The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.~~

~~8. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.~~

~~(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall~~

~~provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

~~2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the office.~~

~~(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.~~

~~(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss for the year shall be recouped by~~

~~assessment of the carriers, as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (m), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.~~

~~b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against~~

~~carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

~~c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.~~

~~3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The~~

~~evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.~~

~~5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.~~

~~6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.~~

~~7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.~~

~~8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred~~

~~may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.~~

~~(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.~~

~~(l) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.~~

~~(m) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such~~

~~administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

~~(n) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:~~

~~1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.~~

~~2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.~~

~~3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.~~

~~4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.~~

~~5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance~~

~~market, results from implementation of previous recommendations, and information on health insurance markets.~~

Section 2. 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)(j) ~~s. 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 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 3. Paragraph (a) of subsection (2), paragraphs (a), (e), and (g) of subsection (7), and paragraph (a) of subsection (8) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.—

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

(a) ~~"Board,"~~ "Carrier~~,~~" and "health benefit plan" have the same meaning ascribed in s. 627.6699(3).

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program ~~established pursuant to s. 627.6699(11)~~. The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.

(e)1. Before March 1 of each calendar year, the board shall determine and report to the office the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier’s premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier’s health benefit plan premiums.

b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier’s earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers

to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the office, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before March 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the office ~~in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program~~.

(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, ~~as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers,~~ including, but not limited to~~, the provisions of s. 627.6699(11) relating to~~:

1. Use of assessments that exceed the amount of actual losses and expenses.

2. The annual determination of each carrier's proportion of the assessment.

3. Interest for late payment of assessments.

4. Authority for the office to approve deferment of an assessment against a carrier.

5. Limited immunity from legal actions or carriers.

6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically enumerated in s. 627.6699(11)(d) ~~s. 627.6699(12)(d)~~.

7. Monitoring compliance by carriers with this section.

(8) STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(11) ~~s. 627.6699(12)~~ that apply to small employer carriers that market policies to small employers shall also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

Section 4. 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)(j) ~~s. 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 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 5. Subsection (1) of section 627.66997, Florida Statutes, is amended to read:

627.66997 Stop-loss insurance.—

(1) A self-insured health benefit plan established or maintained by a small employer, as defined in s. 627.6699(3)(s) ~~s. 627.6699(3)(v)~~, is exempt from s. 627.6699 and may use a stop-loss insurance policy issued to the employer. For purposes of this subsection, the term "stop-loss insurance policy" means an insurance policy issued to a small employer which covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insured health benefit plan.

(a) A small employer stop-loss insurance policy is considered a health insurance policy and is subject to s. 627.6699 if the policy has an aggregate attachment point that is lower than the greatest of:

1. Two thousand dollars multiplied by the number of employees;

2. One hundred twenty percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

3. Twenty thousand dollars.

(b) Once claims under the small employer health benefit plan reach the aggregate attachment point set forth in paragraph (a), the stop-loss insurance policy authorized under this section must cover 100 percent of all claims that exceed the aggregate attachment point.

Section 6. This act shall take effect July 1, 2026.