

By the Committees on Appropriations; and Banking and Insurance

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1 A bill to be entitled
2 An act relating to health insurance; creating s.
3 624.25, F.S.; providing that a provision of the
4 Florida Insurance Code applies unless it conflicts
5 with a provision of the Patient Protection and
6 Affordable Care Act (PPACA); creating s. 624.26, F.S.;
7 authorizing the Office of Insurance Regulation to
8 review forms and perform market conduct examinations
9 for compliance with PPACA and to report potential
10 violations to the federal Department of Health and
11 Human Services; authorizing the Division of Consumer
12 Services of the Department of Financial Services to
13 respond to complaints related to PPACA and to report
14 violations to the office and the Department of Health
15 and Human Services; providing that certain
16 determinations by the office or the Department of
17 Financial Services are not subject to certain
18 challenges under ch. 120, F.S.; amending s. 624.34,
19 F.S.; conforming provisions to changes made by this
20 act with respect to the registration of navigators
21 under the Florida Insurance Code; providing a
22 directive to the Division of Law Revision and
23 Information; creating s. 626.995, F.S.; providing the
24 scope of part XII, ch. 626, F.S.; creating s.
25 626.9951, F.S.; providing definitions; creating s.
26 626.9952, F.S.; requiring the registration of
27 navigators with the Department of Financial Services;
28 providing the purpose for such registration; creating
29 s. 626.9953, F.S.; providing qualifications for

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30 registration; providing for submission of a written
31 application; specifying fees; requiring an applicant
32 to submit fingerprints and pay a processing fee;
33 creating s. 626.9954, F.S.; specifying criteria for
34 disqualification from registration; authorizing the
35 department to adopt rules establishing disqualifying
36 time periods; creating s. 626.9955, F.S.; requiring
37 the department to have a publicly available list of
38 navigators and to report certain information to the
39 exchange; creating s. 626.9956, F.S.; requiring a
40 navigator to notify the department of a change of
41 specified identifying information; creating s.
42 626.9957, F.S.; prohibiting specified conduct;
43 providing grounds for denial, suspension, or
44 revocation of registration; providing for
45 administrative fines and other disciplinary actions;
46 creating s. 626.9958, F.S.; authorizing the department
47 to adopt rules; amending s. 627.402, F.S.; providing
48 definitions for "grandfathered health plan,"
49 "nongrandfathered health plan," and "PPACA"; amending
50 s. 627.410, F.S.; providing an exception to the
51 prohibition against an insurer issuing a new policy
52 form after discontinuing the availability of a similar
53 policy form when the form does not comply with PPACA;
54 requiring the experience of grandfathered health plans
55 and nongrandfathered health plans to be separated;
56 providing that nongrandfathered health plans are not
57 subject to rate review or approval by the office;
58 specifying that such rates for such health plans must

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59 be filed with the office and are exempt from other
60 specified rate requirements; requiring insurers and
61 health maintenance organizations issuing such health
62 plans to include a notice of the estimated impact of
63 PPACA on monthly premiums with the first issuance or
64 renewal of the policy; requiring the Financial
65 Services Commission to adopt the notice format by
66 rule; requiring the notice to be filed with the office
67 for informational purposes; providing for the
68 calculation of the estimated premium impact, which
69 must be included in the notice; requiring the office,
70 in consultation with the department, to develop a
71 summary of the impact to be made available on their
72 respective websites; providing for future repeal;
73 amending s. 627.411, F.S.; providing that grounds for
74 disapproval of rates do not apply to nongrandfathered
75 health plans; providing for future repeal of this
76 provision; amending s. 627.6425, F.S.; allowing an
77 insurer to nonrenew coverage only for all
78 nongrandfathered health plans under certain
79 conditions; amending s. 627.6484, F.S.; providing that
80 coverage for policyholders of the Florida
81 Comprehensive Health Association terminates on a
82 specified date; requiring the association to provide
83 specified assistance to policyholders in obtaining
84 other health insurance coverage; requiring the
85 association to notify policyholders of termination of
86 coverage and information on how to obtain other
87 coverage; requiring the association to determine the

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88 amount of a final assessment or to refund any surplus
89 funds to member insurers, and to otherwise complete
90 program responsibilities; repealing s. 627.64872,
91 related to the Florida Health Insurance Plan;
92 providing for the future repeal of ss. 627.648,
93 627.6482, 627.6484, 627.6486, 627.6488, 627.6489,
94 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and
95 627.6499, F.S., relating to the Florida Comprehensive
96 Health Association; amending s. 627.6571, F.S.;
97 allowing an insurer to nonrenew coverage only for all
98 nongrandfathered health plans under certain
99 conditions; amending s. 627.6675, F.S.; specifying
100 conditions for nonrenewal of a conversion policy;
101 amending s. 627.6699, F.S.; adding and revising
102 definitions used in the Employee Health Care Access
103 Act; providing that a small employer carrier is not
104 required to use gender as a rating factor for a
105 nongrandfathered health plan; requiring carriers to
106 separate the experience of grandfathered health plans
107 and nongrandfathered health plans for determining
108 rates; amending s. 641.31, F.S.; providing that
109 nongrandfathered health plans are not subject to rate
110 review or approval by the office; providing for future
111 repeal of this provision; amending s. 641.3922, F.S.;
112 specifying conditions for nonrenewal of a health
113 maintenance organization conversion contract;
114 providing an appropriation; providing effective dates.

115

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

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

624.25 Patient Protection and Affordable Care Act.—A provision of the Florida Insurance Code, or rule adopted pursuant to the code, applies unless such provision or rule prevents the application of a provision of 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 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 a 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 federal 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

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146 organizations as authorized under s. 624.307, s. 624.3161, or s.
147 641.3905 for compliance with state law, the office may include
148 compliance with PPACA within the scope of such examination or
149 investigation. If the office determines that an insurer's or
150 organization's operations do not comply with PPACA, the office
151 shall inform the insurer or organization of the reason for such
152 determination. If the insurer or organization does not take
153 action to comply with PPACA, the office may report such
154 potential violation to the federal Department of Health and
155 Human Resources.

156 (4) The department's Division of Consumer Services may
157 respond to complaints by consumers relating to a requirement of
158 PPACA as authorized under s. 20.121(2)(h), and report apparent
159 or potential violations to the office and to the federal
160 Department of Health and Human Services.

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

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

167 624.34 Authority of Department of Law Enforcement to accept
168 fingerprints of, and exchange criminal history records with
169 respect to, certain persons.—

170 (2) The Department of Law Enforcement may accept
171 fingerprints of individuals who apply for a license as an agent,
172 customer representative, adjuster, service representative,
173 navigator, or managing general agent or the fingerprints of the
174 majority owner, sole proprietor, partners, officers, and

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175 directors of a corporation or other legal entity that applies
176 for licensure with the department or office under ~~the provisions~~
177 ~~of~~ the Florida Insurance Code.

178 Section 4. The Division of Law Revision and Information is
179 directed to create part XII of chapter 626, Florida Statutes,
180 consisting of ss. 626.995-626.9958, Florida Statutes, and to
181 entitle that part "Navigators."

182 Section 5. Section 626.995, Florida Statutes, is created to
183 read:

184 626.995 Scope of part.-This part applies only to
185 navigators.

186 Section 6. Section 626.9951, Florida Statutes, is created
187 to read:

188 626.9951 Definitions.-As used in this part, the term:

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

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

195 (3) "Navigator" means an individual authorized by an
196 exchange to serve as a navigator, or who works on behalf of an
197 entity authorized by an exchange to serve as a navigator,
198 pursuant to 42 U.S.C. s. 18031(i)(1), who facilitates the
199 selection of a qualified health plan through the exchange and
200 performs any other duties specified under 42 U.S.C. s.
201 18031(i)(3).

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

203 Section 7. Section 626.9952, Florida Statutes, is created

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204 to read:

205 626.9952 Registration required; purpose.-

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

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

216 Section 8. Section 626.9953, Florida Statutes, is created
217 to read:

218 626.9953 Qualifications for registration; application
219 required.-

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

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

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

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

230 (2) To be registered as a navigator, an applicant must
231 submit a sworn, signed, written application to the department on
232 a form prescribed by the department, meet the qualifications for

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233 registration as a navigator, and make payment in advance of all
234 applicable fees. Individuals previously disqualified must apply
235 for reinstatement using the same procedures required for initial
236 registration.

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

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

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

247 (c) His or her native language.

248 (d) His or her highest level of education.

249 (e) A statement of acknowledgement of conduct that is
250 prohibited under this part and the penalties associated with
251 such conduct.

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

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

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

261 (5) An applicant must submit a set of his or her

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262 fingerprints to the department and pay the processing fee
263 established under s. 624.501(24). The department shall submit
264 the applicants' fingerprints to the Department of Law
265 Enforcement for processing state criminal history records checks
266 and local criminal records checks through local law enforcement
267 agencies and for forwarding to the Federal Bureau of
268 Investigation for national criminal history records checks. The
269 fingerprints shall be taken by a law enforcement agency, a
270 designated examination center, or another department-approved
271 entity. The department may not approve an application for
272 registration as a navigator if fingerprints have not been
273 submitted.

274 (6) In addition to information requested in the
275 application, the department may propound any reasonable
276 interrogatories to an applicant relating to the applicant's
277 qualifications, residence, prospective place of business, and
278 any other matters that, in the opinion of the department, are
279 deemed necessary or advisable for the protection of the public
280 and to ascertain the applicant's qualifications. In addition to
281 the submission of fingerprints for criminal background
282 screening, the department may make such further investigations
283 as it may deem advisable of the applicant's character,
284 experience, background, and fitness for registration as
285 specified under this part.

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

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291 Section 9. Section 626.9954, Florida Statutes, is created
292 to read:

293 626.9954 Disqualification from registration.—

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

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

306 (3) For all other crimes not described in subsection (2),
307 the department may adopt rules establishing the process and
308 application of disqualifying periods including:

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

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

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

316 (4) The department may adopt rules providing additional
317 disqualifying periods due to the commitment of multiple crimes
318 and other factors reasonably related to the applicant's criminal
319 history. The rules must provide for mitigating and aggravating

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320 factors. However, mitigation may not result in a disqualifying
321 period of less than 7 years and may not mitigate the
322 disqualifying periods in paragraph (3)(b) or paragraph (3)(c).

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

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

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

335 Section 10. Section 626.9955, Florida Statutes, is created
336 to read:

337 626.9955 Registered navigator list.—Upon approval of an
338 application for registration under this part, the department
339 shall add the name of the registrant to its publicly available
340 list of registered navigators in order for operators of an
341 exchange and other interested parties to validate a navigator's
342 registration.

343 Section 11. Section 626.9956, Florida Statutes, is created
344 to read:

345 626.9956 Notice of change of registrant information.—A
346 navigator must notify the department, in writing, within 30 days
347 after a change of name, residence address, principal business
348 street address, mailing address, contact telephone number,

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349 including a business telephone number, or e-mail address.
350 Failure to notify the department within the required time is
351 subject to a fine of up to \$250 for the first offense, and a
352 fine of at least \$500 or suspension or revocation for a
353 subsequent offense. The department may adopt rules to administer
354 and enforce this section.

355 Section 12. Section 626.9957, Florida Statutes, is created
356 to read:

357 626.9957 Conduct prohibited; denial, revocation, or
358 suspension of registration.-

359 (1) As provided in s. 626.112, only a person licensed as an
360 insurance agent or customer representative may engage in the
361 solicitation of insurance. A person who engages in the
362 solicitation of insurance as described in s. 626.112(1) without
363 such license is subject to the penalties provided under s.
364 626.112(9).

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

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

369 (b) Recommend the purchase of a particular health plan or
370 represent one health plan as preferable over another.

371 (3) A navigator may not:

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

377 (b) Recommend or assist with the cancellation of insurance

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378 coverage purchased outside the exchange; or

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

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

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

390 (b) Violation of department order or rule.

391 (c) Having been the subject of disciplinary or other
392 adverse action by the federal government or an exchange as a
393 result of a violation of any provision of PPACA.

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

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

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

401 (g) Having been found guilty or having pled guilty or nolo
402 contendere to a felony or a crime punishable by imprisonment of
403 1 or more years under the law of the United States or any state
404 thereof or under the law of any country, without regard to
405 whether a judgment of conviction has been entered by the court
406 having jurisdiction of such cases.

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

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

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

422 (5) If the department finds that one or more grounds exist
423 for the suspension or revocation of a navigator's registration,
424 the department may, in lieu of or in addition to suspension or
425 revocation, impose upon the registrant an administrative penalty
426 of up to \$500, or if the department finds willful misconduct or
427 a willful violation, an administrative penalty of up to \$3,500.

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

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

434 (b) A person who violates, or assists in the violation of,
435 an order of the department while such order is in effect, is, at

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436 the discretion of the department, subject to:

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

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

439 (8) If a navigator registered under this part enters a plea
440 of guilty or nolo contendere, or is convicted by a court of a
441 violation of this code or a felony, the registration of such
442 individual shall be immediately revoked by the department. The
443 individual may subsequently request a hearing pursuant to ss.
444 120.569 and 120.57, which shall be expedited by the department.
445 The sole issue at the hearing shall be whether the revocation of
446 registration should be rescinded because such individual was not
447 in fact convicted of a violation of this code or a felony.

448 (9) An order by the department suspending the registration
449 of a navigator must specify the period during which the
450 suspension is to be in effect, which may not exceed 2 years. The
451 registration shall remain suspended during the period specified,
452 subject to rescission or modification of the order by the
453 department, or modification or reversal by the court, before
454 expiration of the suspension period. A registration that has
455 been suspended may not be reinstated except upon the filing and
456 approval of an application for reinstatement; however, the
457 department may not approve an application for reinstatement if
458 it finds that the circumstance or circumstances for which the
459 registration was suspended still exist or are likely to recur.
460 An application for reinstatement is also subject to
461 disqualification and waiting periods before approval on the same
462 grounds that apply to applications for registration under s.
463 626.9954.

464 (10) An individual whose registration has been revoked may

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465 not apply for registration as a navigator until 2 years after
466 the effective date of such revocation or, if judicial review of
467 such revocation is sought, within 2 years after the date of the
468 final court order or decree affirming the revocation.

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

475 (12) The department may adopt rules establishing specific
476 penalties against registrants in accordance with this section.
477 The purpose of revocation or suspension is to provide a
478 sufficient penalty to deter behavior incompatible with the
479 public health, safety, and welfare. The imposition of a
480 revocation or the duration of a suspension shall be based on the
481 type of conduct and the likelihood that the propensity to commit
482 further illegal conduct has been overcome at the time of
483 eligibility for reinstatement. The length of suspension may be
484 adjusted based on aggravating or mitigating factors established
485 by rule and consistent with this purpose.

486 Section 13. Section 626.9958, Florida Statutes, is created
487 to read:

488 626.9958 Rulemaking.—The department may adopt rules to
489 administer this part.

490 Section 14. Section 627.402, Florida Statutes, is amended
491 to read:

492 ~~627.402 Definitions; specified certificates not included.—~~
493 As used in this part, the term:

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

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

503 (3)~~(1)~~ "Policy" means a written contract of insurance or
504 written agreement for or effecting insurance, or the certificate
505 thereof, by whatever name called, and includes all clauses,
506 riders, endorsements, and papers that ~~which~~ are a part thereof.

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

511 (4) "PPACA" means the Patient Protection and Affordable
512 Care Act, Pub. L. No. 111-148, as amended by the Health Care and
513 Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
514 regulations adopted pursuant to those acts.

515 Section 15. Subsections (2), (6), and (7) of section
516 627.410, Florida Statutes, are amended, and subsection (9) is
517 added to that section, to read:

518 627.410 Filing, approval of forms.—

519 (2) Every such filing must be made at least ~~not less than~~
520 30 days in advance of any such use or delivery. At the
521 expiration of the ~~such~~ 30 days, the form ~~so~~ filed will be deemed
522 approved unless prior thereto it has been affirmatively approved

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523 or disapproved by order of the office. The approval of ~~any~~ such
524 form by the office constitutes a waiver of any unexpired portion
525 of such waiting period. The office may extend ~~by not more than~~
526 ~~an additional 15 days~~ the period within which it may ~~so~~
527 affirmatively approve or disapprove ~~any~~ such form by up to 15
528 days, by giving notice of such extension before expiration of
529 the initial 30-day period. At the expiration of ~~any~~ such
530 extended period ~~as so extended~~, and in the absence of ~~such~~ prior
531 affirmative approval or disapproval, ~~any~~ such form shall be
532 deemed approved.

533 (6) (a) An insurer may ~~shall~~ not deliver, ~~or~~ issue for
534 delivery, or renew in this state any health insurance policy
535 form until it has filed with the office a copy of every
536 applicable rating manual, rating schedule, change in rating
537 manual, and change in rating schedule; if rating manuals and
538 rating schedules are not applicable, the insurer must file with
539 the office applicable premium rates and any change in applicable
540 premium rates. This paragraph does not apply to group health
541 insurance policies, effectuated and delivered in this state,
542 insuring groups of 51 or more persons, except for Medicare
543 supplement insurance, long-term care insurance, and any coverage
544 under which the increase in claim costs over the lifetime of the
545 contract due to advancing age or duration is prefunded in the
546 premium.

547 (b) The commission may establish by rule, for each type of
548 health insurance form, procedures to be used in ascertaining the
549 reasonableness of benefits in relation to premium rates and may,
550 by rule, exempt from any requirement of paragraph (a) any health
551 insurance policy form or type thereof, ~~as specified in such~~

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552 rule, ~~+~~ to which form or type such requirements may not be
553 practically applied or to which form or type the application of
554 such requirements is not desirable or necessary for the
555 protection of the public. With respect to any health insurance
556 policy form or type thereof which is exempted by rule from any
557 requirement of paragraph (a), premium rates filed pursuant to
558 ss. 627.640 and 627.662 are ~~shall be~~ for informational purposes.

559 (c) Every filing made pursuant to this subsection shall be
560 made within the same time period ~~provided in~~, and shall be
561 deemed to be approved under the same conditions, as ~~these~~
562 provided in ~~7~~ subsection (2).

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

567 1. Select and ultimate premium schedules.

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

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

573 (e) Except as provided in subparagraph 1., an insurer shall
574 continue to make available for purchase any individual policy
575 form issued on or after October 1, 1993. A policy form is ~~shall~~
576 not ~~be~~ considered to be available for purchase unless the
577 insurer has actively offered it for sale during ~~in~~ the previous
578 12 months.

579 1. An insurer may discontinue the availability of a policy
580 form if the insurer provides its decision to the office in

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581 writing ~~its decision~~ at least 30 days before ~~prior to~~
582 discontinuing the availability of the form of the policy or
583 certificate. After receipt of the notice by the office, the
584 insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or
585 certificate form for sale in this state.

586 2. An insurer that discontinues the availability of a
587 policy form pursuant to subparagraph 1. may ~~shall~~ not file for
588 approval a new policy form providing ~~similar~~ benefits similar to
589 ~~as~~ the discontinued form for ~~a period of~~ 5 years after the
590 insurer provides notice to the office of the discontinuance. The
591 period of discontinuance may be reduced if the office determines
592 that a shorter period is appropriate. The requirements of this
593 subparagraph do not apply to the discontinuance of a policy form
594 because it does not comply with PPACA.

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

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

609 (a) ~~(b)~~ The filing ~~required by this subsection~~ shall be

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610 satisfied by one of the following methods:

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

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

620 (b) ~~(e)~~ As used in this section, the term "actuary" means an
621 individual who is a member of the Society of Actuaries or the
622 American Academy of Actuaries. If an insurer does not employ or
623 otherwise retain the services of an actuary, the insurer's
624 certification shall be prepared by insurer personnel or
625 consultants who have ~~with~~ a minimum of 5 years' experience in
626 insurance ratemaking. The chief executive officer of the insurer
627 shall review and sign the certification indicating his or her
628 agreement with its conclusions.

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

635 (d) ~~(e)~~ If an insurer fails to meet the filing requirements
636 of this subsection and does not submit the filing within 60 days
637 after ~~following~~ the date the filing is due, the office may, in
638 addition to any other penalty authorized by law, order the

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639 insurer to discontinue the issuance of policies for which the
640 required filing was not made~~r~~, until such time as the office
641 determines that the required filing is properly submitted.

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

650 (a) For each individual and small group nongrandfathered
651 health plan, an insurer or health maintenance organization shall
652 include a notice describing or illustrating the estimated impact
653 of PPACA on monthly premiums with the delivery of the policy or
654 contract or, upon renewal, the premium renewal notice. The
655 notice must be in a format established by rule of the
656 commission. The format must specify how the information required
657 under paragraph (b) is to be described or illustrated, and may
658 allow for specified variations from such requirements in order
659 to provide a more accurate and meaningful disclosure of the
660 estimated impact of PPACA on monthly premiums, as determined by
661 the commission. All notices shall be submitted to the office for
662 informational purposes by September 1, 2013. The notice is
663 required only for the first issuance or renewal of the policy or
664 contract on or after January 1, 2014.

665 (b) The information provided in the notice shall be based
666 on the statewide average premium for the policy or contract for
667 the bronze, silver, gold, or platinum level plan, whichever is

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668 applicable to the policy or contract, and provide an estimate of
669 the following effects of PPACA requirements:

670 1. The dollar amount of the premium which is attributable
671 to the impact of guaranteed issuance of coverage. This estimate
672 must include, but is not required to itemize, the impact of the
673 requirement that rates be based on factors unrelated to health
674 status, how the individual coverage mandate and subsidies
675 provided in the health insurance exchange established in this
676 state pursuant to PPACA affect the impact of guaranteed issuance
677 of coverage, and estimated reinsurance credits.

678 2. The dollar amount of the premium which is attributable
679 to fees, taxes, and assessments.

680 3. For individual policies or contracts, the dollar amount
681 of the premium increase or decrease from the premium that would
682 have otherwise been due which is attributable to the combined
683 impact of the requirement that rates for age be limited to a 3-
684 to-1 ratio and the prohibition against using gender as a rating
685 factor. This estimate must be displayed for the average rates
686 for male and female insureds, respectively, for the following
687 three age categories: age 21 years to 29 years, age 30 years to
688 54 years, and age 55 years to 64 years.

689 4. The dollar amount which is attributable to the
690 requirement that essential health benefits be provided and to
691 meet the required actuarial value for the product, as compared
692 to the statewide average premium for the policy or contract for
693 the plan issued by that insurer or organization that has the
694 highest enrollment in the individual or small group market on
695 July 1, 2013, whichever is applicable. The statewide average
696 premiums for the plan that has the highest enrollment must

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697 include all policyholders, including those that have health
698 conditions that increase the standard premium.

699 (c) The office, in consultation with the department, shall
700 develop a summary of the estimated impact of PPACA on monthly
701 premiums as contained in the notices submitted by insurers and
702 health maintenance organizations, which must be available on the
703 respective websites of the office and department by October 1,
704 2013.

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

706 Section 16. Subsection (4) is added to section 627.411,
707 Florida Statutes, to read:

708 627.411 Grounds for disapproval.—

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

713 Section 17. Paragraph (a) of subsection (3) of section
714 627.6425, Florida Statutes, is amended to read:

715 627.6425 Renewability of individual coverage.—

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

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

724 2. The insurer offers to each individual in the individual
725 market provided coverage under this policy form the option to

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726 purchase any other individual health insurance coverage
727 currently being offered by the insurer for individuals in such
728 market in the state; and

729 3. In exercising the option to discontinue coverage of a
730 ~~this~~ policy form and in offering the option of coverage under
731 subparagraph 2., the insurer acts uniformly without regard to
732 any health-status-related factor of enrolled individuals or
733 individuals who may become eligible for such coverage. If a
734 policy form covers both grandfathered and nongrandfathered
735 health plans, an insurer may nonrenew coverage only for the
736 nongrandfathered health plans, in which case the requirements of
737 subparagraphs 1. and 2. apply only to the nongrandfathered
738 health plans. As used in this subparagraph, the terms
739 "grandfathered health plan" and "nongrandfathered health plan"
740 have the same meaning as provided in s. 627.402.

741 Section 18. Section 627.6484, Florida Statutes, is amended
742 to read:

743 627.6484 Dissolution of association; termination of
744 enrollment; availability of other coverage.-

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

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

753 (3) The association must provide assistance to each
754 policyholder concerning how to obtain health insurance coverage.

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755 Such assistance must include the identification of insurers and
756 health maintenance organizations offering coverage in the
757 individual market, including inside and outside of the health
758 insurance exchange established in this state pursuant to PPACA
759 as defined in s. 627.402, a basic explanation of the levels of
760 coverage available, and specific information relating to local
761 and online sources from which a policyholder may obtain detailed
762 policy and premium comparisons and directly obtain coverage.

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

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

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

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

778 (d) Contact information for a representative of the
779 association who is able to provide additional information about
780 obtaining individual health insurance coverage both inside and
781 outside of the Health Insurance Exchange.

782 (5) After termination of coverage, the association must
783 continue to receive and process timely submitted claims in

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784 accordance with the laws of this state.

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

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

792 (a) Complete performance of all program responsibilities.

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

795 (c) Make a final accounting of the finances of the
796 association.

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

799 (e) Execute a legal dissolution of the association and
800 report such action to the Chief Financial Officer, the Insurance
801 Commissioner, the President of the Senate, and the Speaker of
802 the House of Representatives. ~~Upon receipt of an application for~~
803 ~~insurance, the association shall issue coverage for an eligible~~
804 ~~applicant. When appropriate, the administrator shall forward a~~
805 ~~copy of the application to a market assistance plan created by~~
806 ~~the office, which shall conduct a diligent search of the private~~
807 ~~marketplace for a carrier willing to accept the application.~~

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

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813 ~~participate in the plan.~~

814 ~~(3) Guidelines for the use of such program shall be a part~~
815 ~~of the association's plan of operation. The guidelines shall~~
816 ~~describe which types of applications are to be exempt from~~
817 ~~submission to the market assistance plan. An exemption shall be~~
818 ~~based upon a determination that due to a specific health~~
819 ~~condition an applicant is ineligible for coverage in the~~
820 ~~standard market. The guidelines shall also describe how the~~
821 ~~market assistance plan is to be conducted, and how the periodic~~
822 ~~reviews to depopulate the association are to be conducted.~~

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

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

838 Section 19. Section 627.64872, Florida Statutes, is
839 repealed.

840 Section 20. Effective October 1, 2015, sections 627.648,
841 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649,

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842 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida
843 Statutes, are repealed.

844 Section 21. Paragraph (a) of subsection (3) of section
845 627.6571, Florida Statutes, is amended to read:

846 627.6571 Guaranteed renewability of coverage.—

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

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

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

860 3. In exercising the option to discontinue coverage of this
861 form and in offering the option of coverage under subparagraph
862 2., the insurer acts uniformly without regard to the claims
863 experience of those policyholders or any health-status-related
864 factor that relates to any participants or beneficiaries covered
865 or new participants or beneficiaries who may become eligible for
866 such coverage. If a policy form covers both grandfathered and
867 nongrandfathered health plans, an insurer may nonrenew coverage
868 only for nongrandfathered health plans, in which case the
869 requirements of subparagraphs 1. and 2. apply only to the
870 nongrandfathered health plans. As used in this subparagraph, the

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871 terms "grandfathered health plan" and "nongrandfathered health
872 plan" have the same meanings as provided in s. 627.402.

873 Section 22. Subsection (6) and paragraph (b) of subsection
874 (7) of section 627.6675, Florida Statutes, are amended to read:

875 627.6675 Conversion on termination of eligibility.—Subject
876 to all of the provisions of this section, a group policy
877 delivered or issued for delivery in this state by an insurer or
878 nonprofit health care services plan that provides, on an
879 expense-incurred basis, hospital, surgical, or major medical
880 expense insurance, or any combination of these coverages, shall
881 provide that an employee or member whose insurance under the
882 group policy has been terminated for any reason, including
883 discontinuance of the group policy in its entirety or with
884 respect to an insured class, and who has been continuously
885 insured under the group policy, and under any group policy
886 providing similar benefits that the terminated group policy
887 replaced, for at least 3 months immediately prior to
888 termination, shall be entitled to have issued to him or her by
889 the insurer a policy or certificate of health insurance,
890 referred to in this section as a "converted policy." A group
891 insurer may meet the requirements of this section by contracting
892 with another insurer, authorized in this state, to issue an
893 individual converted policy, which policy has been approved by
894 the office under s. 627.410. An employee or member shall not be
895 entitled to a converted policy if termination of his or her
896 insurance under the group policy occurred because he or she
897 failed to pay any required contribution, or because any
898 discontinued group coverage was replaced by similar group
899 coverage within 31 days after discontinuance.

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

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

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

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

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

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

926 (7) INFORMATION REQUESTED BY INSURER.—

927 (b) The converted policy may provide that the insurer may
928 refuse to renew the policy or the coverage of any person only

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929 for one or more of the following reasons:

930 1. ~~Either~~ The benefits provided under the sources referred
 931 to in subparagraphs (a)1. and 2. for the person or the benefits
 932 provided or available under the sources referred to in
 933 subparagraph (a)3. for the person, together with the benefits
 934 provided by the converted policy, would result in overinsurance
 935 according to the insurer's standards on file with the office.
 936 The reason for nonrenewal authorized by this subparagraph is not
 937 required to be contained in the converted policy but must be
 938 provided in writing to the policyholder at least 90 days before
 939 the policy renewal date.

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

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

944 4. Other reasons approved by the office.

945 Section 23. Paragraphs (j) through (w) of subsection (3) of
 946 section 627.6699, Florida Statutes, are redesignated as
 947 paragraphs (k) through (x), respectively, a new paragraph (j) is
 948 added to that subsection, present paragraphs (v) and (w) of that
 949 subsection are amended, and paragraph (b) of subsection (6) is
 950 amended, to read:

951 627.6699 Employee Health Care Access Act.—

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

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

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

957 1. For a grandfathered health plan, any person, sole

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958 proprietor, self-employed individual, independent contractor,
959 firm, corporation, partnership, or association that is actively
960 engaged in business, has its principal place of business in this
961 state, employed an average of at least 1 but not more than 50
962 eligible employees on business days during the preceding
963 calendar year, the majority of whom were employed in this state,
964 employs at least 1 employee on the first day of the plan year,
965 and is not formed primarily for purposes of purchasing
966 insurance. In determining the number of ~~eligible~~ employees,
967 companies that are an affiliated group as defined in s. 1504(a)
968 of the Internal Revenue Code of 1986, as amended, are considered
969 a single employer. For purposes of this section, a sole
970 proprietor, an independent contractor, or a self-employed
971 individual is considered a small employer only if all of the
972 conditions and criteria established in this section are met.

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

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

984 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

985 (b) For all small employer health benefit plans that are
986 subject to this section and ~~are~~ issued by small employer

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987 carriers on or after January 1, 1994, premium rates for health
988 benefit plans ~~subject to this section~~ are subject to the
989 following:

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

999 2. Rating factors related to age, gender, family
1000 composition, tobacco use, or geographic location may be
1001 developed by each carrier to reflect the carrier's experience.
1002 The factors used by carriers are subject to office review and
1003 approval.

1004 3. Small employer carriers may not modify the rate for a
1005 small employer for 12 months from the initial issue date or
1006 renewal date, unless the composition of the group changes or
1007 benefits are changed. However, a small employer carrier may
1008 modify the rate one time within the ~~prior to~~ 12 months after the
1009 initial issue date for a small employer who enrolls under a
1010 previously issued group policy that has a common anniversary
1011 date for all employers covered under the policy if:

1012 a. The carrier discloses to the employer in a clear and
1013 conspicuous manner the date of the first renewal and the fact
1014 that the premium may increase on or after that date.

1015 b. The insurer demonstrates to the office that efficiencies

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1016 in administration are achieved and reflected in the rates
1017 charged to small employers covered under the policy.

1018 4. A carrier may issue a group health insurance policy to a
1019 small employer health alliance or other group association with
1020 rates that reflect a premium credit for expense savings
1021 attributable to administrative activities being performed by the
1022 alliance or group association if such expense savings are
1023 specifically documented in the insurer's rate filing and are
1024 approved by the office. Any such credit may not be based on
1025 different morbidity assumptions or on any other factor related
1026 to the health status or claims experience of any person covered
1027 under the policy. ~~Nothing in~~ This subparagraph does not exempt
1028 ~~exempts~~ an alliance or group association from licensure for ~~any~~
1029 activities that require licensure under the insurance code. A
1030 carrier issuing a group health insurance policy to a small
1031 employer health alliance or other group association shall allow
1032 any properly licensed and appointed agent of that carrier to
1033 market and sell the small employer health alliance or other
1034 group association policy. Such agent shall be paid the usual and
1035 customary commission paid to any agent selling the policy.

1036 5. Any adjustments in rates for claims experience, health
1037 status, or duration of coverage may not be charged to individual
1038 employees or dependents. For a small employer's policy, such
1039 adjustments may not result in a rate for the small employer
1040 which deviates more than 15 percent from the carrier's approved
1041 rate. Any such adjustment must be applied uniformly to the rates
1042 charged for all employees and dependents of the small employer.
1043 A small employer carrier may make an adjustment to a small
1044 employer's renewal premium, up to ~~not to exceed~~ 10 percent

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1045 annually, due to the claims experience, health status, or
1046 duration of coverage of the employees or dependents of the small
1047 employer. Semiannually, small group carriers shall report
1048 information on forms adopted by rule by the commission, to
1049 enable the office to monitor the relationship of aggregate
1050 adjusted premiums actually charged policyholders by each carrier
1051 to the premiums that would have been charged by application of
1052 the carrier's approved modified community rates. If the
1053 aggregate resulting from the application of such adjustment
1054 exceeds the premium that would have been charged by application
1055 of the approved modified community rate by 4 percent for the
1056 current reporting period, the carrier shall limit the
1057 application of such adjustments only to minus adjustments
1058 beginning within ~~not more than~~ 60 days after the report is sent
1059 to the office. For any subsequent reporting period, if the total
1060 aggregate adjusted premium actually charged does not exceed the
1061 premium that would have been charged by application of the
1062 approved modified community rate by 4 percent, the carrier may
1063 apply both plus and minus adjustments. A small employer carrier
1064 may provide a credit to a small employer's premium based on
1065 administrative and acquisition expense differences resulting
1066 from the size of the group. Group size administrative and
1067 acquisition expense factors may be developed by each carrier to
1068 reflect the carrier's experience and are subject to office
1069 review and approval.

1070 6. A small employer carrier rating methodology may include
1071 separate rating categories for one dependent child, for two
1072 dependent children, and for three or more dependent children for
1073 family coverage of employees having a spouse and dependent

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1074 children or employees having dependent children only. A small
1075 employer carrier may have fewer, but not greater, numbers of
1076 categories for dependent children than those specified in this
1077 subparagraph.

1078 7. Small employer carriers may not use a composite rating
1079 methodology to rate a small employer with fewer than 10
1080 employees. For the purposes of this subparagraph, the term a
1081 "composite rating methodology" means a rating methodology that
1082 averages the impact of the rating factors for age and gender in
1083 the premiums charged to all of the employees of a small
1084 employer.

1085 8.~~a.~~ A carrier may separate the experience of small
1086 employer groups with fewer ~~less~~ than 2 eligible employees from
1087 the experience of small employer groups with 2-50 eligible
1088 employees for purposes of determining an alternative modified
1089 community rating.

1090 ~~a.b.~~ If a carrier separates the experience of small
1091 employer groups ~~as provided in sub-subparagraph a.~~, the rate to
1092 be charged to small employer groups of fewer ~~less~~ than 2
1093 eligible employees may not exceed 150 percent of the rate
1094 determined for small employer groups of 2-50 eligible employees.
1095 However, the carrier may charge excess losses of the experience
1096 pool consisting of small employer groups with less than 2
1097 eligible employees to the experience pool consisting of small
1098 employer groups with 2-50 eligible employees so that all losses
1099 are allocated and the 150-percent rate limit on the experience
1100 pool consisting of small employer groups with less than 2
1101 eligible employees is maintained.

1102 b. Notwithstanding s. 627.411(1), the rate to be charged to

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1103 a small employer group of fewer than 2 eligible employees,
1104 insured as of July 1, 2002, may be up to 125 percent of the rate
1105 determined for small employer groups of 2-50 eligible employees
1106 for the first annual renewal and 150 percent for subsequent
1107 annual renewals.

1108 9. A carrier shall separate the experience of grandfathered
1109 health plans from nongrandfathered health plans for determining
1110 rates.

1111 Section 24. Paragraph (f) is added to subsection (3) of
1112 section 641.31, Florida Statutes, to read:

1113 641.31 Health maintenance contracts.—

1114 (3)

1115 (f)1. For plan years 2014 and 2015, nongrandfathered health
1116 plans for the individual or small group market are not subject
1117 to rate review or approval by the office. A health maintenance
1118 organization that issues or renews a nongrandfathered health
1119 plan is subject to s. 627.410(9). As used in this paragraph, the
1120 terms "PPACA" and "nongrandfathered health plan" have the same
1121 meanings as those terms are defined in s. 627.402.

1122 2. This paragraph is repealed effective March 1, 2015.

1123 Section 25. Subsection (6) of section 641.3922, Florida
1124 Statutes, is amended and paragraph (h) is added to subsection
1125 (7) of that section, to read:

1126 641.3922 Conversion contracts; conditions.—Issuance of a
1127 converted contract shall be subject to the following conditions:

1128 (6) OPTIONAL COVERAGE.—The health maintenance organization
1129 may ~~shall~~ not be required to issue a converted contract covering
1130 any person if such person is or could be covered by Medicare,
1131 Title XVIII of the Social Security Act, as added by the Social

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1132 Security Amendments of 1965, or as later amended or superseded.
1133 Furthermore, the health maintenance organization is ~~shall~~ not be
1134 required to issue or renew a converted health maintenance
1135 contract covering any person if:

1136 (a)1. The person is covered for similar benefits by another
1137 hospital, surgical, medical, or major medical expense insurance
1138 policy or hospital or medical service subscriber contract or
1139 medical practice or other prepayment plan or by any other plan
1140 or program;

1141 2. The person is eligible for similar benefits, whether
1142 actually ~~or not~~ covered ~~therefor~~, under any arrangement of
1143 coverage for individuals in a group, whether on an insured or
1144 uninsured basis; or

1145 3. Similar benefits are provided for or are available to
1146 the person pursuant to or in accordance with the requirements of
1147 ~~any~~ state or federal law; and

1148 (b) A converted health maintenance contract may include a
1149 provision whereby the health maintenance organization may
1150 request information, in advance of any premium due date of a
1151 health maintenance contract, of any person covered thereunder as
1152 to whether:

1153 1. She or he is covered for similar benefits by another
1154 hospital, surgical, medical, or major medical expense insurance
1155 policy or hospital or medical service subscriber contract or
1156 medical practice or other prepayment plan or by another ~~any~~
1157 ~~other~~ plan or program;

1158 2. She or he is covered for similar benefits under an ~~any~~
1159 arrangement of coverage for individuals in a group, whether on
1160 an insured or uninsured basis; or

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1161 3. Similar benefits are provided for or are available to
1162 the person pursuant to or in accordance with the requirements of
1163 ~~any~~ state or federal law.

1164 (7) REASONS FOR CANCELLATION; TERMINATION.—The converted
1165 health maintenance contract must contain a cancellation or
1166 nonrenewability clause providing that the health maintenance
1167 organization may refuse to renew the contract of any person
1168 covered thereunder, but cancellation or nonrenewal must be
1169 limited to one or more of the following reasons:

1170 (h) The subscriber is covered for similar benefits or
1171 eligible for similar benefits, or similar benefits are provided
1172 for or are available to the subscriber as described in paragraph
1173 (6) (a). The reason for nonrenewal authorized by this paragraph
1174 is not required to be contained in the converted health
1175 maintenance contract but must be provided in writing to the
1176 subscriber at least 90 days before the contract renewal date.

1177 Section 26. For the 2013-2014 fiscal year, the sums of
1178 \$106,658 in recurring funds and \$70,000 in nonrecurring funds
1179 from the Insurance Regulatory Trust Fund and two full-time
1180 equivalent positions and associated salary rate of 72,936 are
1181 appropriated to the Department of Financial Services to
1182 implement the provisions of this act related to the registration
1183 of navigators.

1184 Section 27. Except as otherwise expressly provided in this
1185 act, this act shall take effect upon becoming a law.