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1  
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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117  
118 Section 1. Section 624.25, Florida Statutes, is created to  
119 read:

120 624.25 Patient Protection and Affordable Care Act.—A  
121 provision of the Florida Insurance Code, or rule adopted  
122 pursuant to the code, applies unless such provision or rule  
123 prevents the application of a provision of PPACA. As used in  
124 this section, the term "PPACA" has the same meaning as provided  
125 in s. 627.402.

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

128 624.26 Collaborative arrangement with the Department of  
129 Health and Human Services.—

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

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

144 (3) When performing market conduct examinations or  
145 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 ~~se~~ 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 ~~those~~  
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 ~~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, 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.

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

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

811 ~~(2) The office shall, after consultation with the health~~  
812 ~~insurers licensed in this state, adopt a market assistance plan~~

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813 ~~to assist in the placement of risks of Florida Comprehensive~~  
814 ~~Health Association applicants. All health insurers and health~~  
815 ~~maintenance organizations licensed in this state shall~~  
816 ~~participate in the plan.~~

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

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

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

841 Section 19. Section 627.64872, Florida Statutes, is

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842 repealed.

843 Section 20. Effective October 1, 2015, sections 627.648,  
844 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649,  
845 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida  
846 Statutes, are repealed.

847 Section 21. Paragraph (a) of subsection (3) of section  
848 627.6571, Florida Statutes, is amended to read:

849 627.6571 Guaranteed renewability of coverage.—

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

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

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

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

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871 only for nongrandfathered health plans, in which case the  
872 requirements of subparagraphs 1. and 2. apply only to the  
873 nongrandfathered health plans. As used in this subparagraph, the  
874 terms "grandfathered health plan" and "nongrandfathered health  
875 plan" have the same meanings as provided in s. 627.402.

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

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

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900 failed to pay any required contribution, or because any  
901 discontinued group coverage was replaced by similar group  
902 coverage within 31 days after discontinuance.

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

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

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

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

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

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

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929 (7) INFORMATION REQUESTED BY INSURER.—

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

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

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

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

947 4. Other reasons approved by the office.

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

954 627.6699 Employee Health Care Access Act.—

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

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

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958        (w)~~(v)~~ "Small employer" means, in connection with a health  
959 benefit plan with respect to a calendar year and a plan year:7

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

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

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

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987 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

993 1. Small employer carriers must use a modified community  
994 rating methodology in which the premium for each small employer  
995 is ~~must be~~ determined solely on the basis of the eligible  
996 employee's and eligible dependent's gender, age, family  
997 composition, tobacco use, or geographic area as determined under  
998 paragraph (5)(j) and in which the premium may be adjusted as  
999 permitted by this paragraph. A small employer carrier is not  
1000 required to use gender as a rating factor for a nongrandfathered  
1001 health plan.

1002 2. Rating factors related to age, gender, family  
1003 composition, tobacco use, or geographic location may be  
1004 developed by each carrier to reflect the carrier's experience.  
1005 The factors used by carriers are subject to office review and  
1006 approval.

1007 3. Small employer carriers may not modify the rate for a  
1008 small employer for 12 months from the initial issue date or  
1009 renewal date, unless the composition of the group changes or  
1010 benefits are changed. However, a small employer carrier may  
1011 modify the rate one time within the ~~prior to~~ 12 months after the  
1012 initial issue date for a small employer who enrolls under a  
1013 previously issued group policy that has a common anniversary  
1014 date for all employers covered under the policy if:

1015 a. The carrier discloses to the employer in a clear and

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1016 conspicuous manner the date of the first renewal and the fact  
1017 that the premium may increase on or after that date.

1018 b. The insurer demonstrates to the office that efficiencies  
1019 in administration are achieved and reflected in the rates  
1020 charged to small employers covered under the policy.

1021 4. A carrier may issue a group health insurance policy to a  
1022 small employer health alliance or other group association with  
1023 rates that reflect a premium credit for expense savings  
1024 attributable to administrative activities being performed by the  
1025 alliance or group association if such expense savings are  
1026 specifically documented in the insurer's rate filing and are  
1027 approved by the office. Any such credit may not be based on  
1028 different morbidity assumptions or on any other factor related  
1029 to the health status or claims experience of any person covered  
1030 under the policy. ~~Nothing in~~ This subparagraph does not exempt  
1031 ~~exempts~~ an alliance or group association from licensure for ~~any~~  
1032 activities that require licensure under the insurance code. A  
1033 carrier issuing a group health insurance policy to a small  
1034 employer health alliance or other group association shall allow  
1035 any properly licensed and appointed agent of that carrier to  
1036 market and sell the small employer health alliance or other  
1037 group association policy. Such agent shall be paid the usual and  
1038 customary commission paid to any agent selling the policy.

1039 5. Any adjustments in rates for claims experience, health  
1040 status, or duration of coverage may not be charged to individual  
1041 employees or dependents. For a small employer's policy, such  
1042 adjustments may not result in a rate for the small employer  
1043 which deviates more than 15 percent from the carrier's approved  
1044 rate. Any such adjustment must be applied uniformly to the rates

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1045 charged for all employees and dependents of the small employer.  
1046 A small employer carrier may make an adjustment to a small  
1047 employer's renewal premium, up to ~~not to exceed~~ 10 percent  
1048 annually, due to the claims experience, health status, or  
1049 duration of coverage of the employees or dependents of the small  
1050 employer. Semiannually, small group carriers shall report  
1051 information on forms adopted by rule by the commission, to  
1052 enable the office to monitor the relationship of aggregate  
1053 adjusted premiums actually charged policyholders by each carrier  
1054 to the premiums that would have been charged by application of  
1055 the carrier's approved modified community rates. If the  
1056 aggregate resulting from the application of such adjustment  
1057 exceeds the premium that would have been charged by application  
1058 of the approved modified community rate by 4 percent for the  
1059 current reporting period, the carrier shall limit the  
1060 application of such adjustments only to minus adjustments  
1061 beginning within ~~not more than~~ 60 days after the report is sent  
1062 to the office. For any subsequent reporting period, if the total  
1063 aggregate adjusted premium actually charged does not exceed the  
1064 premium that would have been charged by application of the  
1065 approved modified community rate by 4 percent, the carrier may  
1066 apply both plus and minus adjustments. A small employer carrier  
1067 may provide a credit to a small employer's premium based on  
1068 administrative and acquisition expense differences resulting  
1069 from the size of the group. Group size administrative and  
1070 acquisition expense factors may be developed by each carrier to  
1071 reflect the carrier's experience and are subject to office  
1072 review and approval.

1073 6. A small employer carrier rating methodology may include

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1074 separate rating categories for one dependent child, for two  
1075 dependent children, and for three or more dependent children for  
1076 family coverage of employees having a spouse and dependent  
1077 children or employees having dependent children only. A small  
1078 employer carrier may have fewer, but not greater, numbers of  
1079 categories for dependent children than those specified in this  
1080 subparagraph.

1081 7. Small employer carriers may not use a composite rating  
1082 methodology to rate a small employer with fewer than 10  
1083 employees. For the purposes of this subparagraph, the term a  
1084 "composite rating methodology" means a rating methodology that  
1085 averages the impact of the rating factors for age and gender in  
1086 the premiums charged to all of the employees of a small  
1087 employer.

1088 ~~8.a.~~ A carrier may separate the experience of small  
1089 employer groups with fewer ~~less~~ than 2 eligible employees from  
1090 the experience of small employer groups with 2-50 eligible  
1091 employees for purposes of determining an alternative modified  
1092 community rating.

1093 ~~a.b.~~ If a carrier separates the experience of small  
1094 employer groups ~~as provided in sub-subparagraph a.~~, the rate to  
1095 be charged to small employer groups of fewer ~~less~~ than 2  
1096 eligible employees may not exceed 150 percent of the rate  
1097 determined for small employer groups of 2-50 eligible employees.  
1098 However, the carrier may charge excess losses of the experience  
1099 pool consisting of small employer groups with less than 2  
1100 eligible employees to the experience pool consisting of small  
1101 employer groups with 2-50 eligible employees so that all losses  
1102 are allocated and the 150-percent rate limit on the experience

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1103 pool consisting of small employer groups with less than 2  
1104 eligible employees is maintained.

1105 b. Notwithstanding s. 627.411(1), the rate to be charged to  
1106 a small employer group of fewer than 2 eligible employees,  
1107 insured as of July 1, 2002, may be up to 125 percent of the rate  
1108 determined for small employer groups of 2-50 eligible employees  
1109 for the first annual renewal and 150 percent for subsequent  
1110 annual renewals.

1111 9. A carrier shall separate the experience of grandfathered  
1112 health plans from nongrandfathered health plans for determining  
1113 rates.

1114 Section 24. Paragraph (f) is added to subsection (3) of  
1115 section 641.31, Florida Statutes, to read:

1116 641.31 Health maintenance contracts.—

1117 (3)

1118 (f)1. For plan years 2014 and 2015, nongrandfathered health  
1119 plans for the individual or small group market are not subject  
1120 to rate review or approval by the office. A health maintenance  
1121 organization that issues or renews a nongrandfathered health  
1122 plan is subject to s. 627.410(9). As used in this paragraph, the  
1123 terms "PPACA" and "nongrandfathered health plan" have the same  
1124 meanings as those terms are defined in s. 627.402.

1125 2. This paragraph is repealed effective March 1, 2015.

1126 Section 25. Subsection (6) of section 641.3922, Florida  
1127 Statutes, is amended and paragraph (h) is added to subsection  
1128 (7) of that section, to read:

1129 641.3922 Conversion contracts; conditions.—Issuance of a  
1130 converted contract shall be subject to the following conditions:

1131 (6) OPTIONAL COVERAGE.—The health maintenance organization

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1132 may ~~shall~~ not be required to issue a converted contract covering  
1133 any person if such person is or could be covered by Medicare,  
1134 Title XVIII of the Social Security Act, as added by the Social  
1135 Security Amendments of 1965, or as later amended or superseded.  
1136 Furthermore, the health maintenance organization is ~~shall~~ not be  
1137 required to issue or renew a converted health maintenance  
1138 contract covering any person if:

1139 (a)1. The person is covered for similar benefits by another  
1140 hospital, surgical, medical, or major medical expense insurance  
1141 policy or hospital or medical service subscriber contract or  
1142 medical practice or other prepayment plan or by any other plan  
1143 or program;

1144 2. The person is eligible for similar benefits, whether  
1145 actually ~~or not~~ covered ~~therefor~~, under any arrangement of  
1146 coverage for individuals in a group, whether on an insured or  
1147 uninsured basis; or

1148 3. Similar benefits are provided for or are available to  
1149 the person pursuant to or in accordance with the requirements of  
1150 ~~any~~ state or federal law; and

1151 (b) A converted health maintenance contract may include a  
1152 provision whereby the health maintenance organization may  
1153 request information, in advance of any premium due date of a  
1154 health maintenance contract, of any person covered thereunder as  
1155 to whether:

1156 1. She or he is covered for similar benefits by another  
1157 hospital, surgical, medical, or major medical expense insurance  
1158 policy or hospital or medical service subscriber contract or  
1159 medical practice or other prepayment plan or by another ~~any~~  
1160 ~~other~~ plan or program;

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1161           2. She or he is covered for similar benefits under an ~~any~~  
1162 arrangement of coverage for individuals in a group, whether on  
1163 an insured or uninsured basis; or

1164           3. Similar benefits are provided for or are available to  
1165 the person pursuant to or in accordance with the requirements of  
1166 ~~any~~ state or federal law.

1167           (7) REASONS FOR CANCELLATION; TERMINATION.—The converted  
1168 health maintenance contract must contain a cancellation or  
1169 nonrenewability clause providing that the health maintenance  
1170 organization may refuse to renew the contract of any person  
1171 covered thereunder, but cancellation or nonrenewal must be  
1172 limited to one or more of the following reasons:

1173           (h) The subscriber is covered for similar benefits or  
1174 eligible for similar benefits, or similar benefits are provided  
1175 for or are available to the subscriber as described in paragraph  
1176 (6) (a). The reason for nonrenewal authorized by this paragraph  
1177 is not required to be contained in the converted health  
1178 maintenance contract but must be provided in writing to the  
1179 subscriber at least 90 days before the contract renewal date.

1180           Section 26. For the 2013-2014 fiscal year, the sums of  
1181 \$106,658 in recurring funds and \$70,000 in nonrecurring funds  
1182 from the Insurance Regulatory Trust Fund and two full-time  
1183 equivalent positions and associated salary rate of 72,936 are  
1184 appropriated to the Department of Financial Services to  
1185 implement the provisions of this act related to the registration  
1186 of navigators.

1187           Section 27. Except as otherwise expressly provided in this  
1188 act, this act shall take effect upon becoming a law.