FOR CONSIDERATION By the Committee on Banking and Insurance

597-02756B-13 20137138__

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 conduct 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. 627.402,
19 F.S.; providing definitions for “grandfathered health
20 plan,” “nongrandfathered health plan,” and “PPACA”;
21 amending s. 627.410, F.S.; providing an exception to
22 the prohibition against an insurer issuing a new
23 policy form after discontinuing the availability of a
24 similar policy form when the form does not comply with
25 PPACA; requiring the experience of grandfathered
26 health plans and nongrandfathered health plans to be
27 separated; providing that nongrandfathered health
28 plans are not subject to rate review or approval by
29 the office; specifying that such rates for such health

30 plans must be filed with the office and are exempt
31 from other specified rate requirements; requiring
32 insurers and health maintenance organizations issuing
33 such health plans to include a notice of the estimated
34 impact of PPACA on monthly premiums with the first
35 issuance or renewal of the policy; requiring the
36 Financial Services Commission to adopt the notice
37 format by rule; requiring the notice to be filed with
38 the office for informational purposes; providing for
39 the calculation of the estimated premium impact, which
40 must be included in the notice; requiring the office,
41 in consultation with the department, to develop a
42 summary of the impact to be made available on their
43 respective websites; providing for future repeal;
44 amending s. 627.411, F.S.; providing that grounds for
45 disapproval of rates do not apply to nongrandfathered
46 health plans; providing for future repeal of this
47 provision; amending s. 627.6425, F.S.; allowing an
48 insurer to nonrenew coverage only for all
49 nongrandfathered health plans under certain
50 conditions; amending s. 627.6484, F.S.; providing that
51 coverage for policyholders of the Florida
52 Comprehensive Health Association terminates on a
53 specified date; requiring the association to provide
54 specified assistance to policyholders in obtaining
55 other health insurance coverage; requiring the
56 association to notify policyholders of termination of
57 coverage and information on how to obtain other
58 coverage; requiring the association to determine the

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59 amount of a final assessment or to refund any surplus
60 funds to member insurers, and to otherwise complete
61 program responsibilities; repealing s. 627.64872,
62 related to the Florida Health Insurance Plan;
63 providing for the future repeal of ss. 627.648,
64 627.6482, 627.6484, 627.6486, 627.6488, 627.6489,
65 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and
66 627.6499, F.S., relating to the Florida Comprehensive
67 Health Association; amending s. 627.6571, F.S.;
68 allowing an insurer to nonrenew coverage only for all
69 nongrandfathered health plans under certain
70 conditions; amending s. 627.6699, F.S.; adding and
71 revising definitions used in the Employee Health Care
72 Access Act; providing that a small employer carrier is
73 not required to use gender as a rating factor for a
74 nongrandfathered health plan; requiring carriers to
75 separate the experience of grandfathered health plans
76 and nongrandfathered health plans for determining
77 rates; amending s. 641.31, F.S.; providing that
78 nongrandfathered health plans are not subject to rate
79 review or approval by the office; providing for future
80 repeal of this provision; providing effective dates.
81
82 Be It Enacted by the Legislature of the State of Florida:
83
84 Section 1. Section 624.25, Florida Statutes, is created to
85 read:
86 624.25 Patient Protection and Affordable Care Act.—A
87 provision of the Florida Insurance Code, or rule adopted

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88 pursuant to the code, applies unless such provision or rule
89 prevents the application of a provision of PPACA. As used in
90 this section, the term "PPACA" has the same meaning as provided
91 in s. 627.402.
92 Section 2. Section 624.26, Florida Statutes, is created to
93 read:
94 624.26 Collaborative arrangement with the Department of
95 Health and Human Services.—
96 (1) As used in this section, the term "PPACA" has the same
97 meaning as provided in s. 627.402.
98 (2) When reviewing forms filed by health insurers or health
99 maintenance organizations pursuant to s. 627.410 or s. 641.31(3)
100 for compliance with state law, the office may also review such
101 forms for compliance with PPACA. If the office determines that a
102 form does not comply with PPACA, the office shall inform the
103 insurer or organization of the reason for noncompliance. If the
104 office determines that a form ultimately used by an insurer or
105 organization does not comply with PPACA, the office may report
106 such potential violation to the federal Department of Health and
107 Human Services. The review of forms by the office under this
108 subsection does not include review of the rates, rating
109 practices, or the relationship of benefits to the rates.
110 (3) When performing market conduct examinations or
111 investigations of health insurers or health maintenance
112 organizations as authorized under s. 624.307, s. 624.3161, or s.
113 641.3905 for compliance with state law, the office may include
114 compliance with PPACA within the scope of such examination or
115 investigation. If the office determines that an insurer's or
116 organization's operations do not comply with PPACA, the office

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117 shall inform the insurer or organization of the reason for such
118 determination. If the insurer or organization does not take
119 action to comply with PPACA, the office may report such
120 potential violation to the federal Department of Health and
121 Human Resources.
122 (4) The department's Division of Consumer Services may
123 respond to complaints by consumers relating to a requirement of
124 PPACA as authorized under s. 20.121(2)(h), and report apparent
125 or potential violations to the office and to the federal
126 Department of Health and Human Services.
127 (5) A determination made by the office or department
128 pursuant to this section regarding compliance with PPACA does
129 not constitute a determination that affects the substantial
130 interests of any party for purposes of chapter 120.
131 Section 3. Section 627.402, Florida Statutes, is amended to
132 read:
133 627.402 Definitions; specified certificates not included.—
134 As used in this part, the term:
135 (1) "Grandfathered health plan" has the same meaning as
136 provided in 42 U.S.C. s. 18011, subject to the conditions for
137 maintaining status as a grandfathered health plan specified in
138 regulations adopted by the federal Department of Health and
139 Human Services in 45 C.F.R. s. 147.140.
140 (2) "Nongrandfathered health plan" is a health insurance
141 policy or health maintenance organization contract that is not a
142 grandfathered health plan.
143 (3)(1) "Policy" means a written contract of insurance or
144 written agreement for or effecting insurance, or the certificate
145 thereof, by whatever name called, and includes all clauses,

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146 riders, endorsements, and papers that ~~which~~ are a part thereof.
147 ~~(2)~~ The term ~~word~~ “certificate” as used in this subsection
148 ~~section~~ does not include certificates as to group life or health
149 insurance or as to group annuities issued to individual
150 insureds.
151 (4) “PPACA” means the Patient Protection and Affordable
152 Care Act, Pub. L. No. 111-148, as amended by the Health Care and
153 Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
154 regulations adopted pursuant to those acts.
155 Section 4. Subsections (2), (6), and (7) of section
156 627.410, Florida Statutes, are amended, and subsection (9) is
157 added to that section, to read:
158 627.410 Filing, approval of forms.—
159 (2) Every such filing must be made at least ~~not less than~~
160 30 days in advance of any such use or delivery. At the
161 expiration of the ~~such~~ 30 days, the form ~~so~~ filed will be deemed
162 approved unless prior thereto it has been affirmatively approved
163 or disapproved by order of the office. The approval of ~~any~~ such
164 form by the office constitutes a waiver of any unexpired portion
165 of such waiting period. The office may extend ~~by not more than~~
166 ~~an additional 15 days~~ the period within which it may ~~so~~
167 affirmatively approve or disapprove ~~any~~ such form by up to 15
168 days~~,~~ by giving notice of such extension before expiration of
169 the initial 30-day period. At the expiration of ~~any~~ such
170 extended period ~~as so extended~~, and in the absence of ~~such~~ prior
171 affirmative approval or disapproval, ~~any~~ such form shall be
172 deemed approved.
173 (6)(a) An insurer may ~~shall~~ not deliver, ~~or~~ issue for
174 delivery, or renew in this state any health insurance policy

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175 form until it has filed with the office a copy of every
176 applicable rating manual, rating schedule, change in rating
177 manual, and change in rating schedule; if rating manuals and
178 rating schedules are not applicable, the insurer must file with
179 the office applicable premium rates and any change in applicable
180 premium rates. This paragraph does not apply to group health
181 insurance policies, effectuated and delivered in this state,
182 insuring groups of 51 or more persons, except for Medicare
183 supplement insurance, long-term care insurance, and any coverage
184 under which the increase in claim costs over the lifetime of the
185 contract due to advancing age or duration is prefunded in the
186 premium.
187 (b) The commission may establish by rule, for each type of
188 health insurance form, procedures to be used in ascertaining the
189 reasonableness of benefits in relation to premium rates and may,
190 by rule, exempt from any requirement of paragraph (a) any health
191 insurance policy form or type thereof, (as specified in such
192 rule,) to which form or type such requirements may not be
193 practically applied or to which form or type the application of
194 such requirements is not desirable or necessary for the
195 protection of the public. With respect to any health insurance
196 policy form or type thereof which is exempted by rule from any
197 requirement of paragraph (a), premium rates filed pursuant to
198 ss. 627.640 and 627.662 are shall be for informational purposes.
199 (c) Every filing made pursuant to this subsection shall be
200 made within the same time period provided in, and shall be
201 deemed to be approved under the same conditions, as those
202 provided in, subsection (2).
203 (d) Every filing made pursuant to this subsection, except

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204 disability income policies and accidental death policies, are
205 ~~shall be~~ prohibited from applying the following rating
206 practices:
207 1. Select and ultimate premium schedules.
208 2. Premium class definitions that ~~which~~ classify insured
209 based on year of issue or duration since issue.
210 3. Attained age premium structures on policy forms under
211 which more than 50 percent of the policies are issued to persons
212 age 65 or over.
213 (e) Except as provided in subparagraph 1., an insurer shall
214 continue to make available for purchase any individual policy
215 form issued on or after October 1, 1993. A policy form is ~~shall~~
216 not ~~be~~ considered to be available for purchase unless the
217 insurer has actively offered it for sale during ~~in~~ the previous
218 12 months.
219 1. An insurer may discontinue the availability of a policy
220 form if the insurer provides its decision to the office in
221 writing ~~its decision~~ at least 30 days before ~~prior to~~
222 discontinuing the availability of the form of the policy or
223 certificate. After receipt of the notice by the office, the
224 insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or
225 certificate form for sale in this state.
226 2. An insurer that discontinues the availability of a
227 policy form pursuant to subparagraph 1. may ~~shall~~ not file for
228 approval a new policy form providing ~~similar~~ benefits similar to
229 ~~as~~ the discontinued form for ~~a period of~~ 5 years after the
230 insurer provides notice to the office of the discontinuance. The
231 period of discontinuance may be reduced if the office determines
232 that a shorter period is appropriate. The requirements of this

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233 subparagraph do not apply to the discontinuance of a policy form
234 because it does not comply with PPACA.
235 3. The experience of all policy forms providing similar
236 benefits shall be combined for all rating purposes, except that
237 the experience of grandfathered health plans and
238 nongrandfathered health plans shall be separated.
239 (7) ~~(a)~~ Each insurer subject to ~~the requirements of~~
240 subsection (6) shall make an annual filing with the office
241 within ~~no later than~~ 12 months after its previous filing,
242 demonstrating the reasonableness of benefits in relation to
243 premium rates. ~~The office,~~ After receiving a request to be
244 exempted from the provisions of this section, the office may,
245 for good cause due to insignificant numbers of policies in force
246 or insignificant premium volume, exempt a company, by line of
247 coverage, from filing rates or rate certification as required by
248 this section.
249 (a) ~~(b)~~ The filing ~~required by this subsection~~ shall be
250 satisfied by one of the following methods:
251 1. A rate filing prepared by an actuary which contains
252 documentation demonstrating the reasonableness of benefits in
253 relation to premiums charged in accordance with the applicable
254 rating laws and rules adopted ~~promulgated~~ by the commission.
255 2. If no rate change is proposed, a filing that ~~which~~
256 consists of a certification by an actuary that benefits are
257 reasonable in relation to premiums currently charged in
258 accordance with applicable laws and rules promulgated by the
259 commission.
260 (b) ~~(c)~~ As used in this section, the term “actuary” means an
261 individual who is a member of the Society of Actuaries or the

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262 American Academy of Actuaries. If an insurer does not employ or
263 otherwise retain the services of an actuary, the insurer's
264 certification shall be prepared by insurer personnel or
265 consultants who have ~~with~~ a minimum of 5 years' experience in
266 insurance ratemaking. The chief executive officer of the insurer
267 shall review and sign the certification indicating his or her
268 agreement with its conclusions.
269 (c) ~~(d)~~ If at the time a filing is required ~~under this~~
270 ~~section~~ an insurer is in the process of completing a rate
271 review, the insurer may apply to the office for an extension of
272 up to an additional 30 days in which to make the filing. The
273 request for extension must be received by the office by ~~no later~~
274 ~~than~~ the date the filing is due.
275 (d) ~~(e)~~ If an insurer fails to meet the filing requirements
276 of this subsection and does not submit the filing within 60 days
277 after ~~following~~ the date the filing is due, the office may, in
278 addition to any other penalty authorized by law, order the
279 insurer to discontinue the issuance of policies for which the
280 required filing was not made~~,~~ until such time as the office
281 determines that the required filing is properly submitted.
282 (9) For plan years 2014 and 2015, nongrandfathered health
283 plans for the individual or small group market are not subject
284 to rate review or approval by the office. An insurer or health
285 maintenance organization issuing or renewing such health plans
286 shall file rates and any change in rates with the office as
287 required by paragraph (6)(a), but the filing and rates are not
288 subject to subsection (2), paragraphs (b), (c), or (d) of
289 subsection (6), or subsection (7). The filing shall also include
290 the notice to policyholders required under this subsection.

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291 (a) For each nongrandfathered health plan, an insurer or
292 health maintenance organization shall include a notice
293 describing or illustrating the estimated impact of PPACA on
294 monthly premiums with the delivery of the policy or contract or,
295 upon renewal, the premium renewal notice. The notice must be in
296 a format established by rule of the commission. All notices
297 shall be submitted to the office for informational purposes by
298 September 1, 2013. The notice is required only for the first
299 issuance or renewal of the policy or contract on or after
300 January 1, 2014.
301 (b) The information provided in the notice shall be based
302 on the statewide average premium for the policy or contract for
303 the bronze, silver, gold, or platinum level plan, whichever is
304 applicable to the policy or contract, and provide an estimate of
305 the following effects of PPACA requirements:
306 1. The dollar amount of the premium which is attributable
307 to the impact of guaranteed issuance of coverage. This estimate
308 must include, but is not required to itemize, the impact of the
309 requirement that rates be based on factors unrelated to health
310 status, how the individual coverage mandate and subsidies
311 provided in the exchange affect the impact of guaranteed
312 issuance of coverage, and estimated reinsurance credits.
313 2. The dollar amount of the premium which is attributable
314 to fees, taxes, and assessments.
315 3. For individual policies or contracts, the dollar amount
316 of the premium increase or decrease from the premium that would
317 have otherwise been due which is attributable to the combined
318 impact of the requirement that rates for age be limited to a 3-
319 to-1 ratio and the prohibition against using gender as a rating

320 factor. This estimate must be displayed for the average rates
321 for male and female insureds, respectively, for the following
322 three age categories: age 21 years to 29 years, age 30 years to
323 54 years, and age 55 years to 64 years.
324 4. The dollar amount which is attributable to the
325 requirement that essential health benefits be provided and to
326 meet the required actuarial value for the product, as compared
327 to the statewide average premium for the policy or contract for
328 the plan that has the highest enrollment in the individual or
329 small group market on July 1, 2013, whichever is applicable. The
330 statewide average premiums for the plan that has the highest
331 enrollment must include all policyholders, including those that
332 have health conditions that increase the standard premium.
333 (c) The office, in consultation with the department, shall
334 develop a summary of the estimated impact of PPACA on monthly
335 premiums as contained in the notices submitted by insurers and
336 health maintenance organizations, which must be available on the
337 respective websites of the office and department by October 1,
338 2013.
339 (d) This subsection is repealed on March 1, 2015.
340 Section 5. Subsection (4) is added to section 627.411,
341 Florida Statutes, to read:
342 627.411 Grounds for disapproval.—
343 (4) The provisions of this section which apply to rates,
344 rating practices, or the relationship of benefits to the premium
345 charged do not apply to nongrandfathered health plans described
346 in s. 627.410(9). This subsection is repealed on July 1, 2015.
347 Section 6. Paragraph (a) of subsection (3) of section
348 627.6425, Florida Statutes, is amended to read:

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349 627.6425 Renewability of individual coverage.—
350 (3)(a) If ~~In any case in which~~ an insurer decides to
351 discontinue offering a particular policy form for health
352 insurance coverage offered in the individual market, coverage
353 under such form may be discontinued by the insurer only if:
354 1. The insurer provides notice to each covered individual
355 provided coverage under this policy form in the individual
356 market of such discontinuation at least 90 days before ~~prior to~~
357 the date of the nonrenewal of such coverage;
358 2. The insurer offers to each individual in the individual
359 market provided coverage under this policy form the option to
360 purchase any other individual health insurance coverage
361 currently being offered by the insurer for individuals in such
362 market in the state; and
363 3. In exercising the option to discontinue coverage of a
364 ~~this~~ policy form and in offering the option of coverage under
365 subparagraph 2., the insurer acts uniformly without regard to
366 any health-status-related factor of enrolled individuals or
367 individuals who may become eligible for such coverage. If a
368 policy form covers both grandfathered and nongrandfathered
369 health plans, an insurer may nonrenew coverage only for the
370 nongrandfathered health plans, in which case the requirements of
371 subparagraphs 1. and 2. apply only to the nongrandfathered
372 health plans. As used in this subparagraph, the terms
373 "grandfathered health plan" and "nongrandfathered health plan"
374 have the same meaning as provided in s. 627.402.
375 Section 7. Section 627.6484, Florida Statutes, is amended
376 to read:
377 627.6484 Dissolution of association; termination of

378 enrollment; availability of other coverage.—
379 (1) The association shall accept applications for insurance
380 only until June 30, 1991, after which date no further
381 applications may be accepted.
382 (2) Coverage for each policyholder of the association
383 terminates at midnight, June 30, 2014, or on the date that
384 health insurance coverage is effective with another insurer,
385 whichever occurs first, and such terminated coverage may not be
386 renewed.
387 (3) The association must provide assistance to each
388 policyholder concerning how to obtain health insurance coverage.
389 Such assistance must include the identification of insurers and
390 health maintenance organizations offering coverage in the
391 individual market, including inside and outside of the Health
392 Insurance Exchange, a basic explanation of the levels of
393 coverage available, and specific information relating to local
394 and online sources from which a policyholder may obtain detailed
395 policy and premium comparisons and directly obtain coverage.
396 (4) The association shall provide written notice to all
397 policyholders by September 1, 2013, which informs each
398 policyholder with respect to:
399 (a) The date that coverage with the association is
400 terminated and that such coverage may not be renewed.
401 (b) The opportunity for the policyholder to obtain
402 individual health insurance coverage on a guaranteed-issue
403 basis, regardless of the policyholder's health status, from any
404 health insurer or health maintenance organization that offers
405 coverage in the individual market, including the dates of open
406 enrollment periods for obtaining such coverage.

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407 (c) How to access coverage through the Health Insurance
408 Exchange established for this state pursuant to the Patient
409 Protection and Affordable Care Act and the potential for
410 obtaining reduced premiums and cost-sharing provisions depending
411 on the policyholder’s family income level.
412 (d) Contact information for a representative of the
413 association who is able to provide additional information about
414 obtaining individual health insurance coverage both inside and
415 outside of the Health Insurance Exchange.
416 (5) After termination of coverage, the association must
417 continue to receive and process timely submitted claims in
418 accordance with the laws of this state.
419 (6) By March 15, 2015, the association must determine the
420 final assessment to be collected from insurers for funding
421 claims and administrative expenses of the association or, if
422 surplus funds remain, determine the refund amount to be provided
423 to each insurer based on the same pro rata formula used in
424 determining each insurer’s assessment.
425 (7) By September 1, 2015, the board must:
426 (a) Complete performance of all program responsibilities.
427 (b) Sell or otherwise dispose of all physical assets of the
428 association.
429 (c) Make a final accounting of the finances of the
430 association.
431 (d) Transfer all records to the Office of Insurance
432 Regulation, which shall serve as custodian of such records.
433 (e) Execute a legal dissolution of the association and
434 report such action to the Chief Financial Officer, the Insurance
435 Commissioner, the President of the Senate, and the Speaker of

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436 the House of Representatives. ~~Upon receipt of an application for~~
437 ~~insurance, the association shall issue coverage for an eligible~~
438 ~~applicant. When appropriate, the administrator shall forward a~~
439 ~~copy of the application to a market assistance plan created by~~
440 ~~the office, which shall conduct a diligent search of the private~~
441 ~~marketplace for a carrier willing to accept the application.~~
442 ~~(2) The office shall, after consultation with the health~~
443 ~~insurers licensed in this state, adopt a market assistance plan~~
444 ~~to assist in the placement of risks of Florida Comprehensive~~
445 ~~Health Association applicants. All health insurers and health~~
446 ~~maintenance organizations licensed in this state shall~~
447 ~~participate in the plan.~~
448 ~~(3) Guidelines for the use of such program shall be a part~~
449 ~~of the association's plan of operation. The guidelines shall~~
450 ~~describe which types of applications are to be exempt from~~
451 ~~submission to the market assistance plan. An exemption shall be~~
452 ~~based upon a determination that due to a specific health~~
453 ~~condition an applicant is ineligible for coverage in the~~
454 ~~standard market. The guidelines shall also describe how the~~
455 ~~market assistance plan is to be conducted, and how the periodic~~
456 ~~reviews to depopulate the association are to be conducted.~~
457 ~~(4) If a carrier is found through the market assistance~~
458 ~~plan, the individual shall apply to that company. If the~~
459 ~~individual's application is accepted, association coverage shall~~
460 ~~terminate upon the effective date of the coverage with the~~
461 ~~private carrier. For the purpose of applying a preexisting~~
462 ~~condition limitation or exclusion, any carrier accepting a risk~~
463 ~~pursuant to this section shall provide coverage as if it began~~
464 ~~on the date coverage was effectuated on behalf of the~~

465 ~~association, and shall be indemnified by the association for~~
466 ~~claims costs incurred as a result of utilizing such effective~~
467 ~~date.~~
468 ~~(5) The association shall establish a policyholder~~
469 ~~assistance program by July 1, 1991, to assist in placing~~
470 ~~eligible policyholders in other coverage programs, including~~
471 ~~Medicare and Medicaid.~~
472 Section 8. <u>Section 627.64872, Florida Statutes, is</u>
473 <u>repealed.</u>
474 Section 9. <u>Effective October 1, 2015, sections 627.648,</u>
475 <u>627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649,</u>
476 <u>627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida</u>
477 <u>Statutes, are repealed.</u>
478 Section 10. Paragraph (a) of subsection (3) of section
479 627.6571, Florida Statutes, is amended to read:
480 627.6571 Guaranteed renewability of coverage.—
481 (3)(a) An insurer may discontinue offering a particular
482 policy form of group health insurance coverage offered in the
483 small-group market or large-group market only if:
484 1. The insurer provides notice to each policyholder
485 provided coverage <u>under</u> ~~of~~ this <u>policy</u> form ~~in such market~~, and
486 to participants and beneficiaries covered under such coverage,
487 of such discontinuation at least 90 days <u>before</u> ~~prior to~~ the
488 date of the nonrenewal of such coverage;
489 2. The insurer offers to each policyholder provided
490 coverage <u>under</u> ~~of~~ this <u>policy</u> form ~~in such market~~ the option to
491 purchase all, or in the case of the large-group market, any
492 other health insurance coverage currently being offered by the
493 insurer in such market; and

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494 3. In exercising the option to discontinue coverage of this
495 form and in offering the option of coverage under subparagraph
496 2., the insurer acts uniformly without regard to the claims
497 experience of those policyholders or any health-status-related
498 factor that relates to any participants or beneficiaries covered
499 or new participants or beneficiaries who may become eligible for
500 such coverage. If a policy form covers both grandfathered and
501 nongrandfathered health plans, an insurer may nonrenew coverage
502 only for nongrandfathered health plans, in which case the
503 requirements of subparagraphs 1. and 2. apply only to the
504 nongrandfathered health plans. As used in this subparagraph, the
505 terms "grandfathered health plan" and "nongrandfathered health
506 plan" have the same meanings as provided in s. 627.402.
507 Section 11. Paragraphs (j) through (w) of subsection (3) of
508 section 627.6699, Florida Statutes, are redesignated as
509 paragraphs (k) through (x), respectively, a new paragraph (j) is
510 added to that subsection, present paragraphs (v) and (w) of that
511 subsection are amended, and paragraph (b) of subsection (6) is
512 amended, to read:
513 627.6699 Employee Health Care Access Act.—
514 (3) DEFINITIONS.—As used in this section, the term:
515 (j) "Grandfathered health plan" and "nongrandfathered
516 health plan" have the same meaning as provided in s. 627.402.
517 (w) ~~(v)~~ "Small employer" means, in connection with a health
518 benefit plan with respect to a calendar year and a plan year:~~,~~
519 1. For a grandfathered health plan, any person, sole
520 proprietor, self-employed individual, independent contractor,
521 firm, corporation, partnership, or association that is actively
522 engaged in business, has its principal place of business in this

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523 state, employed an average of at least 1 but not more than 50
524 eligible employees on business days during the preceding
525 calendar year, the majority of whom were employed in this state,
526 employs at least 1 employee on the first day of the plan year,
527 and is not formed primarily for purposes of purchasing
528 insurance. In determining the number of ~~eligible~~ employees,
529 companies that are an affiliated group as defined in s. 1504(a)
530 of the Internal Revenue Code of 1986, as amended, are considered
531 a single employer. For purposes of this section, a sole
532 proprietor, an independent contractor, or a self-employed
533 individual is considered a small employer only if all of the
534 conditions and criteria established in this section are met.
535 2. For a nongrandfathered health plan, any employer that
536 has its principal place of business in this state, employed an
537 average of at least 1 but not more than 50 employees on business
538 days during the preceding calendar year, and employs at least 1
539 employee on the first day of the plan year. As used in this
540 subparagraph, the terms “employee” and “employer” have the same
541 meaning as provided in s. 3 of the Employee Retirement Income
542 Security Act of 1974, as amended, 29 U.S.C. 1002.
543 (x) ~~(w)~~ “Small employer carrier” means a carrier that offers
544 health benefit plans covering ~~eligible~~ employees of one or more
545 small employers.
546 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
547 (b) For all small employer health benefit plans that are
548 subject to this section and ~~are~~ issued by small employer
549 carriers on or after January 1, 1994, premium rates for health
550 benefit plans ~~subject to this section~~ are subject to the
551 following:

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552 1. Small employer carriers must use a modified community
553 rating methodology in which the premium for each small employer
554 is ~~must be~~ determined solely on the basis of the eligible
555 employee’s and eligible dependent’s gender, age, family
556 composition, tobacco use, or geographic area as determined under
557 paragraph (5)(j) and in which the premium may be adjusted as
558 permitted by this paragraph. A small employer carrier is not
559 required to use gender as a rating factor for a nongrandfathered
560 health plan.
561 2. Rating factors related to age, gender, family
562 composition, tobacco use, or geographic location may be
563 developed by each carrier to reflect the carrier’s experience.
564 The factors used by carriers are subject to office review and
565 approval.
566 3. Small employer carriers may not modify the rate for a
567 small employer for 12 months from the initial issue date or
568 renewal date, unless the composition of the group changes or
569 benefits are changed. However, a small employer carrier may
570 modify the rate one time within the ~~prior to~~ 12 months after the
571 initial issue date for a small employer who enrolls under a
572 previously issued group policy that has a common anniversary
573 date for all employers covered under the policy if:
574 a. The carrier discloses to the employer in a clear and
575 conspicuous manner the date of the first renewal and the fact
576 that the premium may increase on or after that date.
577 b. The insurer demonstrates to the office that efficiencies
578 in administration are achieved and reflected in the rates
579 charged to small employers covered under the policy.
580 4. A carrier may issue a group health insurance policy to a

581 small employer health alliance or other group association with
582 rates that reflect a premium credit for expense savings
583 attributable to administrative activities being performed by the
584 alliance or group association if such expense savings are
585 specifically documented in the insurer’s rate filing and are
586 approved by the office. Any such credit may not be based on
587 different morbidity assumptions or on any other factor related
588 to the health status or claims experience of any person covered
589 under the policy. ~~Nothing in~~ This subparagraph does not exempt
590 ~~exempts~~ an alliance or group association from licensure for ~~any~~
591 activities that require licensure under the insurance code. A
592 carrier issuing a group health insurance policy to a small
593 employer health alliance or other group association shall allow
594 any properly licensed and appointed agent of that carrier to
595 market and sell the small employer health alliance or other
596 group association policy. Such agent shall be paid the usual and
597 customary commission paid to any agent selling the policy.
598 5. Any adjustments in rates for claims experience, health
599 status, or duration of coverage may not be charged to individual
600 employees or dependents. For a small employer’s policy, such
601 adjustments may not result in a rate for the small employer
602 which deviates more than 15 percent from the carrier’s approved
603 rate. Any such adjustment must be applied uniformly to the rates
604 charged for all employees and dependents of the small employer.
605 A small employer carrier may make an adjustment to a small
606 employer’s renewal premium, up to ~~not to exceed~~ 10 percent
607 annually, due to the claims experience, health status, or
608 duration of coverage of the employees or dependents of the small
609 employer. Semiannually, small group carriers shall report

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610 information on forms adopted by rule by the commission, to
611 enable the office to monitor the relationship of aggregate
612 adjusted premiums actually charged policyholders by each carrier
613 to the premiums that would have been charged by application of
614 the carrier's approved modified community rates. If the
615 aggregate resulting from the application of such adjustment
616 exceeds the premium that would have been charged by application
617 of the approved modified community rate by 4 percent for the
618 current reporting period, the carrier shall limit the
619 application of such adjustments only to minus adjustments
620 beginning <u>within</u> ~~not more than~~ 60 days after the report is sent
621 to the office. For any subsequent reporting period, if the total
622 aggregate adjusted premium actually charged does not exceed the
623 premium that would have been charged by application of the
624 approved modified community rate by 4 percent, the carrier may
625 apply both plus and minus adjustments. A small employer carrier
626 may provide a credit to a small employer's premium based on
627 administrative and acquisition expense differences resulting
628 from the size of the group. Group size administrative and
629 acquisition expense factors may be developed by each carrier to
630 reflect the carrier's experience and are subject to office
631 review and approval.
632 6. A small employer carrier rating methodology may include
633 separate rating categories for one dependent child, for two
634 dependent children, and for three or more dependent children for
635 family coverage of employees having a spouse and dependent
636 children or employees having dependent children only. A small
637 employer carrier may have fewer, but not greater, numbers of
638 categories for dependent children than those specified in this

639 subparagraph.
640 7. Small employer carriers may not use a composite rating
641 methodology to rate a small employer with fewer than 10
642 employees. For the purposes of this subparagraph, the term ~~a~~
643 “composite rating methodology” means a rating methodology that
644 averages the impact of the rating factors for age and gender in
645 the premiums charged to all of the employees of a small
646 employer.
647 8.~~a.~~ A carrier may separate the experience of small
648 employer groups with fewer ~~less~~ than 2 eligible employees from
649 the experience of small employer groups with 2-50 eligible
650 employees for purposes of determining an alternative modified
651 community rating.
652 a.~~b.~~ If a carrier separates the experience of small
653 employer groups ~~as provided in sub-subparagraph a.~~, the rate to
654 be charged to small employer groups of fewer ~~less~~ than 2
655 eligible employees may not exceed 150 percent of the rate
656 determined for small employer groups of 2-50 eligible employees.
657 However, the carrier may charge excess losses of the experience
658 pool consisting of small employer groups with less than 2
659 eligible employees to the experience pool consisting of small
660 employer groups with 2-50 eligible employees so that all losses
661 are allocated and the 150-percent rate limit on the experience
662 pool consisting of small employer groups with less than 2
663 eligible employees is maintained.
664 b. Notwithstanding s. 627.411(1), the rate to be charged to
665 a small employer group of fewer than 2 eligible employees,
666 insured as of July 1, 2002, may be up to 125 percent of the rate
667 determined for small employer groups of 2-50 eligible employees

668 for the first annual renewal and 150 percent for subsequent
669 annual renewals.
670 9. A carrier shall separate the experience of grandfathered
671 health plans from nongrandfathered health plans for determining
672 rates.
673 Section 12. Paragraph (f) is added to subsection (3) of
674 section 641.31, Florida Statutes, to read:
675 641.31 Health maintenance contracts.—
676 (3)
677 (f)1. For plan years 2014 and 2015, nongrandfathered health
678 plans for the individual or small group market are not subject
679 to rate review or approval by the office. A health maintenance
680 organization that issues or renews a nongrandfathered health
681 plan is subject to s. 627.410(9). As used in this paragraph, the
682 terms "PPACA" and "nongrandfathered health plan" have the same
683 meanings as those terms are defined in s. 627.402.
684 2. This paragraph is repealed effective March 1, 2015.
685 Section 13. This act shall take effect upon becoming a law.

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