A bill to be entitled

An act relating to health insurance; creating s. 624.25, F.S.; providing for applicability of Florida Insurance Code and rules with respect to Patient Protection and Affordable Care Act (PPACA); creating s. 624.26, F.S.; authorizing the Office of Insurance Regulation to review forms and perform market conduct examinations for compliance with PPACA and to report potential violations to the United States Department of Health and Human Services; authorizing the Division of Consumer Services of the Department of Financial Services to respond to complaints related to PPACA and to report violations to the office and the United States Department of Health and Human Services; providing that certain determinations by the office or the Department of Financial Services related to compliance with PPACA are not decisions that affect a party's substantial interests for purposes of ch. 120, F.S.; amending s. 627.402, F.S.; defining the terms "grandfathered health plan," "nongrandfathered health plan," and "PPACA"; amending s. 627.410, F.S.; providing an exception to the prohibition against an insurer issuing a new policy form after discontinuing the availability of a similar policy form when the form does not comply with PPACA; requiring the experience of grandfathered health plans and nongrandfathered health plans to be separated; providing that nongrandfathered health plans are not

subject to rate review or approval by the office; specifying that such rates for such health plans must be filed with the office and are exempt from other specified rate requirements; requiring insurers and health maintenance organizations issuing such health plans to include a notice of the estimated impact of PPACA on monthly premiums with the first issuance or renewal of the policy; requiring the Financial Services Commission to adopt the format for the notice by rule; requiring the notice to be filed with the office for informational purposes; providing for the calculation of the estimated premium impact; requiring the office, in consultation with the Department of Financial Services, to develop a summary of the impact to be made available on their respective websites; providing for future repeal; amending s. 627.411, F.S.; providing that grounds for disapproval of rates do not apply to nongrandfathered health plans; providing for future repeal; amending s. 627.642, F.S.; conforming a cross-reference; amending s. 627.6425, F.S.; allowing an insurer to nonrenew coverage only for all nongrandfathered health plans under certain conditions; amending s. 627.6484, F.S.; providing that coverage for each policyholder of the Florida Comprehensive Health Association terminates on a specified date; requiring the association to provide assistance to policyholders; requiring the association to notify policyholders of termination of coverage and

provide information concerning how to obtain other coverage; requiring the association to impose a final assessment or provide a refund to member insurers, sell or dispose of physical assets, perform a final accounting, legally dissolve the association, submit a required report, transfer all records to the Department of Financial Services, and transfer remaining funds of the association to the Chief Financial Officer for deposit in the General Revenue Fund; repealing s. 627.64872, F.S., relating to the Florida Health Insurance Plan; providing for the future repeal of ss. 627.648, 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, F.S., relating to the Florida Comprehensive Health Association Act, definitions, termination of enrollment and availability of other coverage, eligibility, the Florida Comprehensive Health Association, the Disease Management Program, the administrator of the health insurance plan, participation of insurers, insurer assessments, deferment, and assessment limitations, issuing of policies, minimum benefits coverage and exclusions, premiums, and deductibles, and reporting by insurers and third-party administrators, respectively; amending s. 627.657, F.S.; conforming a cross-reference; amending s. 627.6571, F.S.; allowing an insurer to nonrenew coverage only for all nongrandfathered health

plans under certain conditions; amending s. 627.6699, F.S.; adding and revising definitions used in the Employee Health Care Access Act; providing that a small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan; requiring carriers to separate the experience of grandfathered health plans and nongrandfathered health plans for determining rates; amending s. 641.31, F.S.; providing that nongrandfathered health plans are not subject to rate review or approval by the office; providing for future repeal; providing effective dates.

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

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

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

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

624.26 Collaborative arrangement with the United States Department of Health and Human Services.—

(1) As used in this section, the term "PPACA" has the same

meaning as provided in s. 627.402.

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

(3) When performing market conduct examinations or investigations of health insurers or health maintenance organizations as authorized under s. 624.307, s. 624.3161, or s. 641.3905 for compliance with state law, the office may include compliance with PPACA within the scope of such examination or investigation. If the office determines that an insurer's or organization's operations do not comply with PPACA, the office shall inform the insurer or organization of the reason for such determination. If the insurer or organization does not take action to comply with PPACA, the office may report such potential violation to the United States Department of Health and Human Services.

(4) The department's Division of Consumer Services may respond to complaints by consumers relating to a requirement of

PPACA as authorized under s. 20.121(2)(h) and report apparent or potential violations to the office and to the United States Department of Health and Human Services.

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

Section 3. Section 627.402, Florida Statutes, is amended to read:

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

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

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

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

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

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

Section 4. Subsection (2) of section 627.410, Florida Statutes, is republished, subsection (6) of that section is amended, subsection (7) of that section is republished, and subsection (9) is added to that section, to read:

627.410 Filing, approval of forms.—

(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable

premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

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

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based

on year of issue or duration since issue.

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

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

1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing ~~its decision~~ at least 30 days before ~~prior to~~ discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or certificate form for sale in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may ~~shall~~ not file for approval a new policy form providing ~~similar~~ benefits similar to ~~as~~ the discontinued form for ~~a period of~~ 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form due to noncompliance with PPACA.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that

the experience of grandfathered health plans and nongrandfathered health plans shall be separated.

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

(b) The filing required by this subsection shall be satisfied by one of the following methods:

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

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

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the

certification indicating his or her agreement with its conclusions.

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

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

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

(a) For each individual and small group nongrandfathered health plan, an insurer or health maintenance organization shall include a notice describing or illustrating the estimated impact of PPACA on monthly premiums with the delivery of the policy or contract or, upon renewal, the premium renewal notice. The

notice shall be in a format established by rule of the commission. All notices shall be submitted to the office for informational purposes by September 1, 2013. The notice is required only for the first issuance or renewal of the policy or contract on or after January 1, 2014.

(b) The notice shall be based on the statewide average premium for the policy or contract form for the bronze-level, silver-level, gold-level, or platinum-level plan, whichever is applicable to the policy or contract, and shall estimate the following effects of PPACA requirements:

1. The dollar amount of the premium that is due to the impact of guaranteed issuance of coverage. This estimate must include, but not necessarily itemize, the impact of the requirement that rates may not be based on any health status-related factors, how the individual coverage mandate and subsidies provided in the health insurance exchange established in this state pursuant to PPACA affect the impact of guaranteed issuance of coverage, and estimated reinsurance credits.

2. The dollar amount of the premium that is due to fees, taxes, and assessments.

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

and age 55 years to 64 years.

4. The dollar amount due to the requirement to provide essential health benefits and to meet the required actuarial value for the product, as compared to the statewide average premium for the policy or contract for the plan issued by that insurer or organization that has the highest enrollment in the individual or small group market on July 1, 2013, whichever is applicable. The statewide average premiums for the plan with the highest enrollment must include all policyholders, including those policyholders with health conditions that increase the standard premium.

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

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

Section 5. Subsection (4) is added to section 627.411, Florida Statutes, to read:

627.411 Grounds for disapproval.—

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

Section 6. Subsection (3) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(l) ~~627.6699(3)(k)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or the name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the United States ~~federal~~ Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic

stripe or smart card. The information may also be provided through other electronic technology.

Section 7. Paragraph (a) of subsection (3) of section 627.6425, Florida Statutes, is amended to read:

627.6425 Renewability of individual coverage.—

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

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

2. The insurer offers to each individual in the individual market provided coverage under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and

3. In exercising the option to discontinue coverage of a ~~this~~ policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage. If a policy form covers both grandfathered and nongrandfathered health plans, an insurer may nonrenew coverage only for the nongrandfathered health plans, in which case the requirements of subparagraphs 1. and 2. apply only to the nongrandfathered health plans. As used in this subparagraph, the terms

"grandfathered health plan" and "nongrandfathered health plan" have the same meaning as provided in s. 627.402.

Section 8. Section 627.6484, Florida Statutes, is amended to read:

627.6484 Dissolution of association; termination of enrollment; availability of other coverage.—

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

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

(3) The association must provide assistance to each policyholder concerning how to obtain health insurance coverage. Such assistance shall include the identification of insurers and health maintenance organizations offering coverage in the individual market, including inside and outside of the health insurance exchange established in this state pursuant to PPACA as defined in s. 627.402, a basic explanation of the levels of coverage available, and specific information relating to local and online sources where each policyholder may obtain detailed policy and premium comparisons and directly obtain coverage.

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

(a) The date that coverage with the association is

terminated and that such coverage may not be renewed.

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

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

(d) Contact information for a representative of the association who is able to provide additional information about obtaining individual health insurance coverage both inside and outside of the health insurance exchange.

(5) After termination of coverage, the association must continue to receive and process timely submitted claims in accordance with the laws of this state.

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

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

(a) Complete performance of all program responsibilities.

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

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

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

(e) Execute a legal dissolution of the association and report such action to the Chief Financial Officer, the Insurance Commissioner, the President of the Senate, and the Speaker of the House of Representatives.

(f) Transfer any remaining funds of the association to the Chief Financial Officer for deposit in the General Revenue Fund. ~~Upon receipt of an application for insurance, the association shall issue coverage for an eligible applicant. When appropriate, the administrator shall forward a copy of the application to a market assistance plan created by the office, which shall conduct a diligent search of the private marketplace for a carrier willing to accept the application.~~

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

~~(3) Guidelines for the use of such program shall be a part of the association's plan of operation. The guidelines shall describe which types of applications are to be exempt from submission to the market assistance plan. An exemption shall be based upon a determination that due to a specific health condition an applicant is ineligible for coverage in the~~

~~standard market. The guidelines shall also describe how the market assistance plan is to be conducted, and how the periodic reviews to depopulate the association are to be conducted.~~

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

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

Section 9. Section 627.64872, Florida Statutes, is repealed.

Section 10. Effective October 1, 2015, sections 627.648, 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida Statutes, are repealed.

Section 11. Subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s. 627.6699(3)(l)

~~627.6699(3)(k)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the United States ~~federal~~ Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 12. Paragraph (a) of subsection (3) of section 627.6571, Florida Statutes, is amended to read:

627.6571 Guaranteed renewability of coverage.—

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

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

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

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

"nongrandfathered health plan" have the same meanings as provided in s. 627.402.

Section 13. Paragraphs (j) through (w) of subsection (3) of section 627.6699, Florida Statutes, are redesignated as paragraphs (k) through (x), respectively, a new paragraph (j) is added to that subsection, present paragraphs (v) and (w) of that subsection are amended, and paragraph (b) of subsection (6) is amended, to read:

627.6699 Employee Health Care Access Act.—

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

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

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

(a) For a grandfathered health plan, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of ~~eligible~~ employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed

individual is considered a small employer only if all of the conditions and criteria established in this section are met.

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

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

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

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

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered

under the policy. ~~Nothing in~~ This subparagraph does not exempt ~~exempts~~ an alliance or group association from licensure for ~~any~~ activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to ~~not to exceed~~ 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the commission, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application

of the approved modified community rate by 4 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning within ~~not more than~~ 60 days after the report is sent to the office. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

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

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term ~~a~~ "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in

the premiums charged to all of the employees of a small employer.

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

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

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

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

Section 14. Paragraph (f) is added to subsection (3) of section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(3)

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

2. This paragraph is repealed March 1, 2015.

Section 15. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.