1 A bill to be entitled
2 An act relating to health insurance; creating s.
3 624.25, F.S.; providing for applicability of Florida
4 Insurance Code and rules with respect to Patient
5 Protection and Affordable Care Act (PPACA); creating
6 s. 624.26, F.S.; authorizing the Office of Insurance
7 Regulation to review forms and perform market conduct
8 examinations for compliance with PPACA and to report
9 potential violations to the United States Department
10 of Health and Human Services; authorizing the Division
11 of Consumer Services of the Department of Financial
12 Services to respond to complaints related to PPACA and
13 to report violations to the office and the United
14 States Department of Health and Human Services;
15 providing that certain determinations by the office or
16 the Department of Financial Services related to
17 compliance with PPACA are not decisions that affect a
18 party's substantial interests for purposes of ch. 120,
19 F.S.; amending s. 627.402, F.S.; defining the terms
20 "grandfathered health plan," "nongrandfathered health
21 plan," and "PPACA"; amending s. 627.410, F.S.;
22 providing an exception to the prohibition against an
23 insurer issuing a new policy form after discontinuing
24 the availability of a similar policy form when the
25 form does not comply with PPACA; requiring the
26 experience of grandfathered health plans and
27 nongrandfathered health plans to be separated;
28 providing that nongrandfathered health plans are not

29 subject to rate review or approval by the office;
30 specifying that such rates for such health plans must
31 be filed with the office and are exempt from other
32 specified rate requirements; requiring insurers and
33 health maintenance organizations issuing such health
34 plans to include a notice of the estimated impact of
35 PPACA on monthly premiums with the first issuance or
36 renewal of the policy; requiring the Financial
37 Services Commission to adopt the format for the notice
38 by rule; requiring the notice to be filed with the
39 office for informational purposes; providing for the
40 calculation of the estimated premium impact; requiring
41 the office, in consultation with the Department of
42 Financial Services, to develop a summary of the impact
43 to be made available on their respective websites;
44 providing for future repeal; amending s. 627.411,
45 F.S.; providing that grounds for disapproval of rates
46 do not apply to nongrandfathered health plans;
47 providing for future repeal; amending s. 627.642,
48 F.S.; conforming a cross-reference; amending s.
49 627.6425, F.S.; allowing an insurer to nonrenew
50 coverage only for all nongrandfathered health plans
51 under certain conditions; amending s. 627.6484, F.S.;
52 providing that coverage for each policyholder of the
53 Florida Comprehensive Health Association terminates on
54 a specified date; requiring the association to provide
55 assistance to policyholders; requiring the association
56 to notify policyholders of termination of coverage and

57 provide information concerning how to obtain other
58 coverage; requiring the association to impose a final
59 assessment or provide a refund to member insurers,
60 sell or dispose of physical assets, perform a final
61 accounting, legally dissolve the association, submit a
62 required report, transfer all records to the
63 Department of Financial Services, and transfer
64 remaining funds of the association to the Chief
65 Financial Officer for deposit in the General Revenue
66 Fund; repealing s. 627.64872, F.S., relating to the
67 Florida Health Insurance Plan; providing for the
68 future repeal of ss. 627.648, 627.6482, 627.6484,
69 627.6486, 627.6488, 627.6489, 627.649, 627.6492,
70 627.6494, 627.6496, 627.6498, and 627.6499, F.S.,
71 relating to the Florida Comprehensive Health
72 Association Act, definitions, termination of
73 enrollment and availability of other coverage,
74 eligibility, the Florida Comprehensive Health
75 Association, the Disease Management Program, the
76 administrator of the health insurance plan,
77 participation of insurers, insurer assessments,
78 deferment, and assessment limitations, issuing of
79 policies, minimum benefits coverage and exclusions,
80 premiums, and deductibles, and reporting by insurers
81 and third-party administrators, respectively; amending
82 s. 627.657, F.S.; conforming a cross-reference;
83 amending s. 627.6571, F.S.; allowing an insurer to
84 nonrenew coverage only for all nongrandfathered health

85 plans under certain conditions; amending s. 627.6699,
86 F.S.; adding and revising definitions used in the
87 Employee Health Care Access Act; providing that a
88 small employer carrier is not required to use gender
89 as a rating factor for a nongrandfathered health plan;
90 requiring carriers to separate the experience of
91 grandfathered health plans and nongrandfathered health
92 plans for determining rates; amending s. 641.31, F.S.;
93 providing that nongrandfathered health plans are not
94 subject to rate review or approval by the office;
95 providing for future repeal; providing effective
96 dates.
97
98 Be It Enacted by the Legislature of the State of Florida:
99
100 Section 1. Section 624.25, Florida Statutes, is created to
101 read:
102 624.25 Florida Insurance Code; applicability with respect
103 to Patient Protection and Affordable Care Act.—A provision of
104 the Florida Insurance Code, or any rule adopted pursuant to the
105 code, applies unless such provision or rule prevents the
106 application of a provision of PPACA. As used in this section,
107 the term "PPACA" has the same meaning as provided in s. 627.402.
108 Section 2. Section 624.26, Florida Statutes, is created to
109 read:
110 624.26 Collaborative arrangement with the United States
111 Department of Health and Human Services.—
112 (1) As used in this section, the term "PPACA" has the same

113 meaning as provided in s. 627.402.
114 (2) When reviewing forms filed by health insurers or
115 health maintenance organizations pursuant to s. 627.410 or s.
116 641.31(3) for compliance with state law, the office may also
117 review such forms for compliance with PPACA. If the office
118 determines that the form does not comply with PPACA, the office
119 shall inform the insurer or organization of the reason for
120 noncompliance. If the office determines that a form ultimately
121 used by an insurer or organization does not comply with PPACA,
122 the office may report such potential violation to the United
123 States Department of Health and Human Services. The review of
124 forms by the office under this subsection does not include
125 review of the rates, rating practices, or the relationship of
126 benefits to the rates.
127 (3) When performing market conduct examinations or
128 investigations of health insurers or health maintenance
129 organizations as authorized under s. 624.307, s. 624.3161, or s.
130 641.3905 for compliance with state law, the office may include
131 compliance with PPACA within the scope of such examination or
132 investigation. If the office determines that an insurer's or
133 organization's operations do not comply with PPACA, the office
134 shall inform the insurer or organization of the reason for such
135 determination. If the insurer or organization does not take
136 action to comply with PPACA, the office may report such
137 potential violation to the United States Department of Health
138 and Human Services.
139 (4) The department's Division of Consumer Services may
140 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.

(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

169 Care Act, Pub. L. No. 111-148, as amended by the Health Care and
170 Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
171 regulations adopted pursuant to those federal acts.
172 Section 4. Subsection (2) of section 627.410, Florida
173 Statutes, is republished, subsection (6) of that section is
174 amended, subsection (7) of that section is republished, and
175 subsection (9) is added to that section, to read:
176 627.410 Filing, approval of forms.—
177 (2) Every such filing must be made not less than 30 days
178 in advance of any such use or delivery. At the expiration of
179 such 30 days, the form so filed will be deemed approved unless
180 prior thereto it has been affirmatively approved or disapproved
181 by order of the office. The approval of any such form by the
182 office constitutes a waiver of any unexpired portion of such
183 waiting period. The office may extend by not more than an
184 additional 15 days the period within which it may so
185 affirmatively approve or disapprove any such form, by giving
186 notice of such extension before expiration of the initial 30-day
187 period. At the expiration of any such period as so extended, and
188 in the absence of such prior affirmative approval or
189 disapproval, any such form shall be deemed approved.
190 (6)(a) An insurer shall not deliver or issue for delivery
191 or renew in this state any health insurance policy form until it
192 has filed with the office a copy of every applicable rating
193 manual, rating schedule, change in rating manual, and change in
194 rating schedule; if rating manuals and rating schedules are not
195 applicable, the insurer must file with the office applicable
196 premium rates and any change in applicable premium rates. This

197 paragraph does not apply to group health insurance policies,
198 effectuated and delivered in this state, insuring groups of 51
199 or more persons, except for Medicare supplement insurance, long-
200 term care insurance, and any coverage under which the increase
201 in claim costs over the lifetime of the contract due to
202 advancing age or duration is prefunded in the premium.
203 (b) The commission may establish by rule, for each type of
204 health insurance form, procedures to be used in ascertaining the
205 reasonableness of benefits in relation to premium rates and may,
206 by rule, exempt from any requirement of paragraph (a) any health
207 insurance policy form or type thereof (as specified in such
208 rule) to which form or type such requirements may not be
209 practically applied or to which form or type the application of
210 such requirements is not desirable or necessary for the
211 protection of the public. With respect to any health insurance
212 policy form or type thereof which is exempted by rule from any
213 requirement of paragraph (a), premium rates filed pursuant to
214 ss. 627.640 and 627.662 shall be for informational purposes.
215 (c) Every filing made pursuant to this subsection shall be
216 made within the same time period provided in, and shall be
217 deemed to be approved under the same conditions as those
218 provided in, subsection (2).
219 (d) Every filing made pursuant to this subsection, except
220 disability income policies and accidental death policies, shall
221 be prohibited from applying the following rating practices:
222 1. Select and ultimate premium schedules.
223 2. Premium class definitions which classify insured based
224 on year of issue or duration since issue.

225 3. Attained age premium structures on policy forms under
226 which more than 50 percent of the policies are issued to persons
227 age 65 or over.
228 (e) Except as provided in subparagraph 1., an insurer
229 shall continue to make available for purchase any individual
230 policy form issued on or after October 1, 1993. A policy form <u>is</u>
231 ~~shall~~ not ~~be~~ considered to be available for purchase unless the
232 insurer has actively offered it for sale <u>during</u> ~~in~~ the previous
233 12 months.
234 1. An insurer may discontinue the availability of a policy
235 form if the insurer provides <u>its decision</u> to the office in
236 writing ~~its decision~~ at least 30 days <u>before</u> ~~prior to~~
237 discontinuing the availability of the form of the policy or
238 certificate. After receipt of the notice by the office, the
239 insurer <u>may</u> ~~shall~~ no longer offer ~~for sale~~ the policy form or
240 certificate form <u>for sale</u> in this state.
241 2. An insurer that discontinues the availability of a
242 policy form pursuant to subparagraph 1. <u>may</u> ~~shall~~ not file for
243 approval a new policy form providing ~~similar~~ benefits <u>similar to</u>
244 ~~as~~ the discontinued form for ~~a period of~~ 5 years after the
245 insurer provides notice to the office of the discontinuance. The
246 period of discontinuance may be reduced if the office determines
247 that a shorter period is appropriate. <u>The requirements of this</u>
248 <u>subparagraph do not apply to the discontinuance of a policy form</u>
249 <u>due to noncompliance with PPACA.</u>
250 3. The experience of all policy forms providing similar
251 benefits shall be combined for all rating purposes<u>, except that</u>
252 <u>the experience of grandfathered health plans and</u>

253 nongrandfathered health plans shall be separated.
254 (7)(a) Each insurer subject to the requirements of
255 subsection (6) shall make an annual filing with the office no
256 later than 12 months after its previous filing, demonstrating
257 the reasonableness of benefits in relation to premium rates. The
258 office, after receiving a request to be exempted from the
259 provisions of this section, may, for good cause due to
260 insignificant numbers of policies in force or insignificant
261 premium volume, exempt a company, by line of coverage, from
262 filing rates or rate certification as required by this section.
263 (b) The filing required by this subsection shall be
264 satisfied by one of the following methods:
265 1. A rate filing prepared by an actuary which contains
266 documentation demonstrating the reasonableness of benefits in
267 relation to premiums charged in accordance with the applicable
268 rating laws and rules promulgated by the commission.
269 2. If no rate change is proposed, a filing which consists
270 of a certification by an actuary that benefits are reasonable in
271 relation to premiums currently charged in accordance with
272 applicable laws and rules promulgated by the commission.
273 (c) As used in this section, "actuary" means an individual
274 who is a member of the Society of Actuaries or the American
275 Academy of Actuaries. If an insurer does not employ or otherwise
276 retain the services of an actuary, the insurer's certification
277 shall be prepared by insurer personnel or consultants with a
278 minimum of 5 years' experience in insurance ratemaking. The
279 chief executive officer of the insurer shall review and sign the
280 certification indicating his or her agreement with its

281 conclusions.
282 (d) If at the time a filing is required under this section
283 an insurer is in the process of completing a rate review, the
284 insurer may apply to the office for an extension of up to an
285 additional 30 days in which to make the filing. The request for
286 extension must be received by the office no later than the date
287 the filing is due.
288 (e) If an insurer fails to meet the filing requirements of
289 this subsection and does not submit the filing within 60 days
290 following the date the filing is due, the office may, in
291 addition to any other penalty authorized by law, order the
292 insurer to discontinue the issuance of policies for which the
293 required filing was not made, until such time as the office
294 determines that the required filing is properly submitted.
295 (9) For plan years 2014 and 2015, nongrandfathered health
296 plans for the individual or small group market are not subject
297 to rate review or approval by the office. An insurer or health
298 maintenance organization issuing or renewing such health plans
299 shall file rates and any change in rates with the office as
300 required by paragraph (6)(a), but the filing and rates are not
301 subject to subsection (2), paragraphs (6)(b)-(d), or subsection
302 (7).
303 (a) For each individual and small group nongrandfathered
304 health plan, an insurer or health maintenance organization shall
305 include a notice describing or illustrating the estimated impact
306 of PPACA on monthly premiums with the delivery of the policy or
307 contract or, upon renewal, the premium renewal notice. The
308 notice shall be in a format established by rule of the

309 commission. All notices shall be submitted to the office for
310 informational purposes by September 1, 2013. The notice is
311 required only for the first issuance or renewal of the policy or
312 contract on or after January 1, 2014.
313 (b) The notice shall be based on the statewide average
314 premium for the policy or contract form for the bronze-level,
315 silver-level, gold-level, or platinum-level plan, whichever is
316 applicable to the policy or contract, and shall estimate the
317 following effects of PPACA requirements:
318 1. The dollar amount of the premium that is due to the
319 impact of guaranteed issuance of coverage. This estimate must
320 include, but not necessarily itemize, the impact of the
321 requirement that rates may not be based on any health status-
322 related factors, how the individual coverage mandate and
323 subsidies provided in the health insurance exchange established
324 in this state pursuant to PPACA affect the impact of guaranteed
325 issuance of coverage, and estimated reinsurance credits.
326 2. The dollar amount of the premium that is due to fees,
327 taxes, and assessments.
328 3. For individual policies or contracts, the dollar amount
329 of the premium increase or decrease, from what the premium would
330 have otherwise been, due to the combined impact of the
331 requirement that rates for age be limited to a 3-to-1 ratio and
332 the prohibition against using gender as a rating factor. This
333 estimate must be displayed for the average rates for male and
334 female insureds, respectively, for the following three age
335 categories: age 21 years to 29 years, age 30 years to 54 years,
336 and age 55 years to 64 years.

337 4. The dollar amount due to the requirement to provide
338 essential health benefits and to meet the required actuarial
339 value for the product, as compared to the statewide average
340 premium for the policy or contract for the plan issued by that
341 insurer or organization that has the highest enrollment in the
342 individual or small group market on July 1, 2013, whichever is
343 applicable. The statewide average premiums for the plan with the
344 highest enrollment must include all policyholders, including
345 those policyholders with health conditions that increase the
346 standard premium.
347 (c) The office, in consultation with the department, shall
348 develop a summary of the estimated impact of PPACA on monthly
349 premiums as contained in the notices submitted by insurers and
350 health maintenance organizations, which must be available on the
351 respective websites of the office and department by October 1,
352 2013.
353 (d) This subsection is repealed March 1, 2015.
354 Section 5. Subsection (4) is added to section 627.411,
355 Florida Statutes, to read:
356 627.411 Grounds for disapproval.—
357 (4) The provisions of this section that apply to rates,
358 rating practices, or the relationship of benefits to the premium
359 charged do not apply to nongrandfathered health plans described
360 in s. 627.410(9). This subsection is repealed July 1, 2015.
361 Section 6. Subsection (3) of section 627.642, Florida
362 Statutes, is amended to read:
363 627.642 Outline of coverage.—
364 (3) In addition to the outline of coverage, a policy as

365 specified in s. 627.6699(3)(l) ~~627.6699(3)(k)~~ must be
366 accompanied by an identification card that contains, at a
367 minimum:
368 (a) The name of the organization issuing the policy or the
369 name of the organization administering the policy, whichever
370 applies.
371 (b) The name of the contract holder.
372 (c) The type of plan only if the plan is filed in the
373 state, an indication that the plan is self-funded, or the name
374 of the network.
375 (d) The member identification number, contract number, and
376 policy or group number, if applicable.
377 (e) A contact phone number or electronic address for
378 authorizations and admission certifications.
379 (f) A phone number or electronic address whereby the
380 covered person or hospital, physician, or other person rendering
381 services covered by the policy may obtain benefits verification
382 and information in order to estimate patient financial
383 responsibility, in compliance with privacy rules under the
384 Health Insurance Portability and Accountability Act.
385 (g) The national plan identifier, in accordance with the
386 compliance date set forth by the United States ~~federal~~
387 Department of Health and Human Services.
388
389 The identification card must present the information in a
390 readily identifiable manner or, alternatively, the information
391 may be embedded on the card and available through magnetic
392 stripe or smart card. The information may also be provided

393 through other electronic technology.
394 Section 7. Paragraph (a) of subsection (3) of section
395 627.6425, Florida Statutes, is amended to read:
396 627.6425 Renewability of individual coverage.—
397 (3)(a) If ~~In any case in which~~ an insurer decides to
398 discontinue offering a particular policy form for health
399 insurance coverage offered in the individual market, coverage
400 under such form may be discontinued by the insurer only if:
401 1. The insurer provides notice to each covered individual
402 provided coverage under this policy form in the individual
403 market of such discontinuation at least 90 days before ~~prior to~~
404 the date of the nonrenewal of such coverage;
405 2. The insurer offers to each individual in the individual
406 market provided coverage under this policy form the option to
407 purchase any other individual health insurance coverage
408 currently being offered by the insurer for individuals in such
409 market in the state; and
410 3. In exercising the option to discontinue coverage of a
411 ~~this~~ policy form and in offering the option of coverage under
412 subparagraph 2., the insurer acts uniformly without regard to
413 any health-status-related factor of enrolled individuals or
414 individuals who may become eligible for such coverage. If a
415 policy form covers both grandfathered and nongrandfathered
416 health plans, an insurer may nonrenew coverage only for the
417 nongrandfathered health plans, in which case the requirements of
418 subparagraphs 1. and 2. apply only to the nongrandfathered
419 health plans. As used in this subparagraph, the terms
420 "grandfathered health plan" and "nongrandfathered health plan"

421 have the same meaning as provided in s. 627.402.
422 Section 8. Section 627.6484, Florida Statutes, is amended
423 to read:
424 627.6484 Dissolution of association; termination of
425 enrollment; availability of other coverage.—
426 (1) The association shall accept applications for
427 insurance only until June 30, 1991, after which date no further
428 applications may be accepted.
429 (2) Coverage for each policyholder of the association
430 shall terminate at midnight on June 30, 2014, or on the date
431 that health insurance coverage is effective with another
432 insurer, whichever occurs first, and such coverage may not be
433 renewed.
434 (3) The association must provide assistance to each
435 policyholder concerning how to obtain health insurance coverage.
436 Such assistance shall include the identification of insurers and
437 health maintenance organizations offering coverage in the
438 individual market, including inside and outside of the health
439 insurance exchange established in this state pursuant to PPACA
440 as defined in s. 627.402, a basic explanation of the levels of
441 coverage available, and specific information relating to local
442 and online sources where each policyholder may obtain detailed
443 policy and premium comparisons and directly obtain coverage.
444 (4) The association shall provide written notice to all
445 policyholders by September 1, 2013, that informs each
446 policyholder with respect to:
447 (a) The date that coverage with the association is
448 terminated and that such coverage may not be renewed.

449 (b) The opportunity for the policyholder to obtain
450 individual health insurance coverage on a guaranteed-issue
451 basis, regardless of the policyholder's health status, from any
452 health insurer or health maintenance organization that offers
453 coverage in the individual market, including the dates of open
454 enrollment periods for obtaining such coverage.
455 (c) How to access coverage through the health insurance
456 exchange and the potential for obtaining reduced premiums and
457 cost-sharing provisions depending on the policyholder's family
458 income level.
459 (d) Contact information for a representative of the
460 association who is able to provide additional information about
461 obtaining individual health insurance coverage both inside and
462 outside of the health insurance exchange.
463 (5) After termination of coverage, the association must
464 continue to receive and process timely submitted claims in
465 accordance with the laws of this state.
466 (6) By March 15, 2015, the association must determine the
467 final assessment to be collected from insurers for funding
468 claims and administrative expenses of the association or, if
469 surplus funds remain, determine the refund amount to be provided
470 to each insurer based on the same pro rata formula used for
471 determining each insurer's assessment.
472 (7) By September 1, 2015, the board must:
473 (a) Complete performance of all program responsibilities.
474 (b) Sell or otherwise dispose of all physical assets of
475 the association.
476 (c) Make a final accounting of the finances of the

477 association.
478 (d) Transfer all records to the Department of Financial
479 Services, which shall serve as custodian of such records.
480 (e) Execute a legal dissolution of the association and
481 report such action to the Chief Financial Officer, the Insurance
482 Commissioner, the President of the Senate, and the Speaker of
483 the House of Representatives.
484 (f) Transfer any remaining funds of the association to the
485 Chief Financial Officer for deposit in the General Revenue Fund.
486 ~~Upon receipt of an application for insurance, the association~~
487 ~~shall issue coverage for an eligible applicant. When~~
488 ~~appropriate, the administrator shall forward a copy of the~~
489 ~~application to a market assistance plan created by the office,~~
490 ~~which shall conduct a diligent search of the private marketplace~~
491 ~~for a carrier willing to accept the application.~~
492 ~~(2) The office shall, after consultation with the health~~
493 ~~insurers licensed in this state, adopt a market assistance plan~~
494 ~~to assist in the placement of risks of Florida Comprehensive~~
495 ~~Health Association applicants. All health insurers and health~~
496 ~~maintenance organizations licensed in this state shall~~
497 ~~participate in the plan.~~
498 ~~(3) Guidelines for the use of such program shall be a part~~
499 ~~of the association's plan of operation. The guidelines shall~~
500 ~~describe which types of applications are to be exempt from~~
501 ~~submission to the market assistance plan. An exemption shall be~~
502 ~~based upon a determination that due to a specific health~~
503 ~~condition an applicant is ineligible for coverage in the~~
504 ~~standard market. The guidelines shall also describe how the~~

505 ~~market assistance plan is to be conducted, and how the periodic~~
506 ~~reviews to depopulate the association are to be conducted.~~
507 ~~(4) If a carrier is found through the market assistance~~
508 ~~plan, the individual shall apply to that company. If the~~
509 ~~individual's application is accepted, association coverage shall~~
510 ~~terminate upon the effective date of the coverage with the~~
511 ~~private carrier. For the purpose of applying a preexisting~~
512 ~~condition limitation or exclusion, any carrier accepting a risk~~
513 ~~pursuant to this section shall provide coverage as if it began~~
514 ~~on the date coverage was effectuated on behalf of the~~
515 ~~association, and shall be indemnified by the association for~~
516 ~~claims costs incurred as a result of utilizing such effective~~
517 ~~date.~~
518 ~~(5) The association shall establish a policyholder~~
519 ~~assistance program by July 1, 1991, to assist in placing~~
520 ~~eligible policyholders in other coverage programs, including~~
521 ~~Medicare and Medicaid.~~
522 Section 9. Section 627.64872, Florida Statutes, is
523 repealed.
524 Section 10. Effective October 1, 2015, sections 627.648,
525 627.6482, 627.6484, 627.6486, 627.6488, 627.6489, 627.649,
526 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, Florida
527 Statutes, are repealed.
528 Section 11. Subsection (2) of section 627.657, Florida
529 Statutes, is amended to read:
530 627.657 Provisions of group health insurance policies.—
531 (2) The medical policy as specified in s. 627.6699(3)(l)
532 ~~627.6699(3)(k)~~ must be accompanied by an identification card

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

533 that contains, at a minimum:
534 (a) The name of the organization issuing the policy or
535 name of the organization administering the policy, whichever
536 applies.
537 (b) The name of the certificateholder.
538 (c) The type of plan only if the plan is filed in the
539 state, an indication that the plan is self-funded, or the name
540 of the network.
541 (d) The member identification number, contract number, and
542 policy or group number, if applicable.
543 (e) A contact phone number or electronic address for
544 authorizations and admission certifications.
545 (f) A phone number or electronic address whereby the
546 covered person or hospital, physician, or other person rendering
547 services covered by the policy may obtain benefits verification
548 and information in order to estimate patient financial
549 responsibility, in compliance with privacy rules under the
550 Health Insurance Portability and Accountability Act.
551 (g) The national plan identifier, in accordance with the
552 compliance date set forth by the United States ~~federal~~
553 Department of Health and Human Services.
554
555 The identification card must present the information in a
556 readily identifiable manner or, alternatively, the information
557 may be embedded on the card and available through magnetic
558 stripe or smart card. The information may also be provided
559 through other electronic technology.
560 Section 12. Paragraph (a) of subsection (3) of section

561 627.6571, Florida Statutes, is amended to read:
562 627.6571 Guaranteed renewability of coverage.—
563 (3)(a) An insurer may discontinue offering a particular
564 policy form of group health insurance coverage offered in the
565 small-group market or large-group market only if:
566 1. The insurer provides notice to each policyholder
567 provided coverage under ~~of~~ this policy form ~~in such market~~, and
568 to participants and beneficiaries covered under such coverage,
569 of such discontinuation at least 90 days before ~~prior to~~ the
570 date of the nonrenewal of such coverage;
571 2. The insurer offers to each policyholder provided
572 coverage under ~~of~~ this policy form ~~in such market~~ the option to
573 purchase all, or in the case of the large-group market, any
574 other health insurance coverage currently being offered by the
575 insurer in such market; and
576 3. In exercising the option to discontinue coverage of
577 this form and in offering the option of coverage under
578 subparagraph 2., the insurer acts uniformly without regard to
579 the claims experience of those policyholders or any health-
580 status-related factor that relates to any participants or
581 beneficiaries covered or new participants or beneficiaries who
582 may become eligible for such coverage. If a policy form covers
583 both grandfathered and nongrandfathered health plans, an insurer
584 may nonrenew coverage only for nongrandfathered health plans, in
585 which case the requirements of subparagraphs 1. and 2. apply
586 only to the nongrandfathered health plans. As used in this
587 subparagraph, the terms "grandfathered health plan" and
588 "nongrandfathered health plan" have the same meanings as

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589 provided in s. 627.402.
590 Section 13. Paragraphs (j) through (w) of subsection (3)
591 of section 627.6699, Florida Statutes, are redesignated as
592 paragraphs (k) through (x), respectively, a new paragraph (j) is
593 added to that subsection, present paragraphs (v) and (w) of that
594 subsection are amended, and paragraph (b) of subsection (6) is
595 amended, to read:
596 627.6699 Employee Health Care Access Act.—
597 (3) DEFINITIONS.—As used in this section, the term:
598 (j) "Grandfathered health plan" and "nongrandfathered
599 health plan" have the same meanings as provided in s. 627.402.
600 (w) ~~(v)~~ "Small employer" means, in connection with a health
601 benefit plan with respect to a calendar year and a plan year:
602 (a) For a grandfathered health plan, any person, sole
603 proprietor, self-employed individual, independent contractor,
604 firm, corporation, partnership, or association that is actively
605 engaged in business, has its principal place of business in this
606 state, employed an average of at least 1 but not more than 50
607 eligible employees on business days during the preceding
608 calendar year, the majority of whom were employed in this state,
609 employs at least 1 employee on the first day of the plan year,
610 and is not formed primarily for purposes of purchasing
611 insurance. In determining the number of ~~eligible~~ employees,
612 companies that are an affiliated group as defined in s. 1504(a)
613 of the Internal Revenue Code of 1986, as amended, are considered
614 a single employer. For purposes of this section, a sole
615 proprietor, an independent contractor, or a self-employed
616 individual is considered a small employer only if all of the

617 conditions and criteria established in this section are met.
618 (b) For a nongrandfathered health plan, any employer that
619 has its principal place of business in this state, employed an
620 average of at least 1 but not more than 50 employees on business
621 days during the preceding calendar year, and employs at least 1
622 employee on the first day of the plan year. As used in this
623 subparagraph, the terms "employee" and "employer" have the same
624 meanings as provided in s. 3 of the Employee Retirement Income
625 Security Act of 1974, as amended, 29 U.S.C. s. 1002.
626 (x) (w) "Small employer carrier" means a carrier that
627 offers health benefit plans covering eligible employees of one
628 or more small employers.
629 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
630 (b) For all small employer health benefit plans that are
631 subject to this section and are issued by small employer
632 carriers on or after January 1, 1994, premium rates for health
633 benefit plans subject to this section are subject to the
634 following:
635 1. Small employer carriers must use a modified community
636 rating methodology in which the premium for each small employer
637 is must be determined solely on the basis of the eligible
638 employee's and eligible dependent's gender, age, family
639 composition, tobacco use, or geographic area as determined under
640 paragraph (5)(j) and in which the premium may be adjusted as
641 permitted by this paragraph. A small employer carrier is not
642 required to use gender as a rating factor for a nongrandfathered
643 health plan.
644 2. Rating factors related to age, gender, family

645 composition, tobacco use, or geographic location may be
646 developed by each carrier to reflect the carrier's experience.
647 The factors used by carriers are subject to office review and
648 approval.
649 3. Small employer carriers may not modify the rate for a
650 small employer for 12 months from the initial issue date or
651 renewal date, unless the composition of the group changes or
652 benefits are changed. However, a small employer carrier may
653 modify the rate one time within the ~~prior to~~ 12 months after the
654 initial issue date for a small employer who enrolls under a
655 previously issued group policy that has a common anniversary
656 date for all employers covered under the policy if:
657 a. The carrier discloses to the employer in a clear and
658 conspicuous manner the date of the first renewal and the fact
659 that the premium may increase on or after that date.
660 b. The insurer demonstrates to the office that
661 efficiencies in administration are achieved and reflected in the
662 rates charged to small employers covered under the policy.
663 4. A carrier may issue a group health insurance policy to
664 a small employer health alliance or other group association with
665 rates that reflect a premium credit for expense savings
666 attributable to administrative activities being performed by the
667 alliance or group association if such expense savings are
668 specifically documented in the insurer's rate filing and are
669 approved by the office. Any such credit may not be based on
670 different morbidity assumptions or on any other factor related
671 to the health status or claims experience of any person covered
672 under the policy. ~~Nothing in~~ This subparagraph does not exempt

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673 ~~exempts~~ an alliance or group association from licensure for ~~any~~
674 activities that require licensure under the insurance code. A
675 carrier issuing a group health insurance policy to a small
676 employer health alliance or other group association shall allow
677 any properly licensed and appointed agent of that carrier to
678 market and sell the small employer health alliance or other
679 group association policy. Such agent shall be paid the usual and
680 customary commission paid to any agent selling the policy.
681 5. Any adjustments in rates for claims experience, health
682 status, or duration of coverage may not be charged to individual
683 employees or dependents. For a small employer's policy, such
684 adjustments may not result in a rate for the small employer
685 which deviates more than 15 percent from the carrier's approved
686 rate. Any such adjustment must be applied uniformly to the rates
687 charged for all employees and dependents of the small employer.
688 A small employer carrier may make an adjustment to a small
689 employer's renewal premium, up to ~~not to exceed~~ 10 percent
690 annually, due to the claims experience, health status, or
691 duration of coverage of the employees or dependents of the small
692 employer. Semiannually, small group carriers shall report
693 information on forms adopted by rule by the commission, to
694 enable the office to monitor the relationship of aggregate
695 adjusted premiums actually charged policyholders by each carrier
696 to the premiums that would have been charged by application of
697 the carrier's approved modified community rates. If the
698 aggregate resulting from the application of such adjustment
699 exceeds the premium that would have been charged by application
700 of the approved modified community rate by 4 percent for the

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V

701 current reporting period, the carrier shall limit the
702 application of such adjustments only to minus adjustments
703 beginning within ~~not more than~~ 60 days after the report is sent
704 to the office. For any subsequent reporting period, if the total
705 aggregate adjusted premium actually charged does not exceed the
706 premium that would have been charged by application of the
707 approved modified community rate by 4 percent, the carrier may
708 apply both plus and minus adjustments. A small employer carrier
709 may provide a credit to a small employer's premium based on
710 administrative and acquisition expense differences resulting
711 from the size of the group. Group size administrative and
712 acquisition expense factors may be developed by each carrier to
713 reflect the carrier's experience and are subject to office
714 review and approval.
715 6. A small employer carrier rating methodology may include
716 separate rating categories for one dependent child, for two
717 dependent children, and for three or more dependent children for
718 family coverage of employees having a spouse and dependent
719 children or employees having dependent children only. A small
720 employer carrier may have fewer, but not greater, numbers of
721 categories for dependent children than those specified in this
722 subparagraph.
723 7. Small employer carriers may not use a composite rating
724 methodology to rate a small employer with fewer than 10
725 employees. For the purposes of this subparagraph, the term ~~a~~
726 "composite rating methodology" means a rating methodology that
727 averages the impact of the rating factors for age and gender in
728 the premiums charged to all of the employees of a small

729 employer.
730 8.~~a.~~ A carrier may separate the experience of small
731 employer groups with fewer ~~less~~ than 2 eligible employees from
732 the experience of small employer groups with 2-50 eligible
733 employees for purposes of determining an alternative modified
734 community rating.
735 a.~~b.~~ If a carrier separates the experience of small
736 employer groups ~~as provided in sub-subparagraph a.~~, the rate to
737 be charged to small employer groups of fewer ~~less~~ than 2
738 eligible employees may not exceed 150 percent of the rate
739 determined for small employer groups of 2-50 eligible employees.
740 However, the carrier may charge excess losses of the experience
741 pool consisting of small employer groups with less than 2
742 eligible employees to the experience pool consisting of small
743 employer groups with 2-50 eligible employees so that all losses
744 are allocated and the 150-percent rate limit on the experience
745 pool consisting of small employer groups with less than 2
746 eligible employees is maintained.
747 b. Notwithstanding s. 627.411(1), the rate to be charged
748 to a small employer group of fewer than 2 eligible employees,
749 insured as of July 1, 2002, may be up to 125 percent of the rate
750 determined for small employer groups of 2-50 eligible employees
751 for the first annual renewal and 150 percent for subsequent
752 annual renewals.
753 9. A carrier shall separate the experience of
754 grandfathered health plans from nongrandfathered health plans
755 for determining rates.
756 Section 14. Paragraph (f) is added to subsection (3) of

757 section 641.31, Florida Statutes, to read:
758 641.31 Health maintenance contracts.—
759 (3)
760 (f)1. For plan years 2014 and 2015, nongrandfathered
761 health plans for the individual or small group market are not
762 subject to rate review or approval by the office. A health
763 maintenance organization that issues or renews a
764 nongrandfathered health plan is subject to s. 627.410(9). As
765 used in this paragraph, the terms "PPACA" and "nongrandfathered
766 health plan" have the same meanings as provided in s. 627.402.
767 2. This paragraph is repealed March 1, 2015.
768 Section 15. Except as otherwise expressly provided in this
769 act, this act shall take effect upon becoming a law.