A bill to be entitled

An act relating to employee health care plans; amending s. 627.6699, F.S.; revising definitions; removing provisions requiring certain insurance carriers to provide semiannual reports to the Office of Insurance Regulation; repealing requirements that certain insurance carriers offer standard, basic, high deductible, and limited health benefit plans; making conforming changes; creating s. 627.66997, F.S.; authorizing certain health benefit plans to use a stop-loss insurance policy; defining the term "stop-loss insurance policy"; providing requirements for such policies; amending ss. 627.642, 627.6475, and 627.657, F.S.; conforming cross-references; amending ss. 627.6571, 627.6675, 641.31074, and 641.3922, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsection (2) of section 627.6699, Florida Statutes, is amended, paragraphs (c) through (x) of subsection (3) are redesignated as paragraphs (b) through (w), respectively, and present paragraphs (b) and (o) of that subsection, subsection (5), paragraph (b) of subsection (6), paragraphs (g), (h), (j), and (l) through (o) of subsection

(11), subsections (12) through (14), paragraph (k) of subsection (15), and subsections (16) through (18) of that section are amended, to read:

627.6699 Employee Health Care Access Act.—

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions~~, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers~~, to provide for establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small group health insurance market.

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

~~(b) "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection (12).~~

(n) ~~(o)~~ "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(f) ~~(5)(j)~~; and allows adjustments for: claims experience, health status, or duration

of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

~~(a) Beginning January 1, 1993, every small employer carrier issuing new health benefit plans to small employers in this state must, as a condition of transacting business in this state, offer to eligible small employers a standard health benefit plan and a basic health benefit plan. Such a small employer carrier shall issue a standard health benefit plan or a basic health benefit plan to every eligible small employer that elects to be covered under such plan, agrees to make the required premium payments under such plan, and to satisfy the other provisions of the plan.~~

(a)~~(b) In the case of~~ A small employer carrier that ~~which~~ does not~~, on or after January 1, 1993,~~ offer coverage but renews or continues ~~which does, on or after January 1, 1993, renew or continue~~ coverage in force must~~, such carrier shall be required to~~ provide coverage to newly eligible employees and dependents on the same basis as small employer carriers that offer ~~which are offering~~ coverage ~~on or after January 1, 1993~~.

(b)~~(c)~~ Every small employer carrier must, as a condition of transacting business in this state,~~:~~

~~1.~~ offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under

such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

~~2. In the absence of enrollment availability in the Florida Health Insurance Plan, offer and issue basic and standard small employer health benefit plans and a high-deductible plan that meets the requirements of a health savings account plan or health reimbursement account as defined by federal law, on a guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his~~

~~or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.~~

~~3. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.~~

~~(d) A small employer carrier must file with the office, in a format and manner prescribed by the committee, a standard health care plan, a high deductible plan that meets the federal requirements of a health savings account plan or a health reimbursement arrangement, and a basic health care plan to be used by the carrier. The provisions of this section requiring the filing of a high deductible plan are effective September 1, 2004.~~

~~(e) The office at any time may, after providing notice and an opportunity for a hearing, disapprove the continued use by the small employer carrier of the standard or basic health benefit plan on the grounds that such plan does not meet the requirements of this section.~~

(c) ~~(f)~~ Except as provided in paragraph (d) ~~(g)~~, a health

benefit plan covering small employers must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.

(d) ~~(g)~~ A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis~~, except that benefits purchased through riders as provided in paragraph (c) may be medically underwritten for the group, but may not be individually underwritten as to the employees or the dependents of such employees~~. Additional or increased benefits may only be offered by riders.

2. ~~The provisions of~~ Paragraph (c) applies ~~(f) apply~~ to health benefit plans issued to a small employer who has two or more eligible employees~~,~~ and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.

3. For health benefit plans that are issued to a small employer who has fewer than two employees and that cover an employee who has not been continually covered by creditable coverage within 63 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's

effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(e) ~~(h)~~ All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no

health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late

enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

~~(i)1. A small employer carrier need not offer coverage or accept applications pursuant to paragraph (a):~~

~~a. To a small employer if the small employer is not physically located in an established geographic service area of the small employer carrier, provided such geographic service area shall not be less than a county;~~

~~b. To an employee if the employee does not work or reside within an established geographic service area of the small employer carrier; or~~

~~c. To a small employer group within an area in which the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the office, that it cannot, within its network of providers, deliver service adequately to the members of such groups because of obligations to existing group contract~~

~~holders and enrollees.~~

~~2. A small employer carrier that cannot offer coverage pursuant to sub-subparagraph 1.c. may not offer coverage in the applicable area to new cases of employer groups having more than 50 eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the office that it has regained its ability to deliver services to small employer groups.~~

~~3.a. A small employer carrier may deny health insurance coverage in the small-group market if the carrier has demonstrated to the office that:~~

~~(I) It does not have the financial reserves necessary to underwrite additional coverage; and~~

~~(II) It is applying this sub-subparagraph uniformly to all employers in the small-group market in this state consistent with this section and without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor that relates to such employees and dependents.~~

~~b. A small employer carrier, upon denying health insurance coverage in connection with health benefit plans in accordance with sub-subparagraph a., may not offer coverage in connection with group health benefit plans in the small-group market in this state for a period of 180 days after the date such coverage is denied or until the insurer has demonstrated to the office that the insurer has sufficient financial reserves to underwrite~~

~~additional coverage, whichever is later. The office may provide for the application of this sub-subparagraph on a service-area-specific basis.~~

~~4. The commission shall, by rule, require each small employer carrier to report, on or before March 1 of each year, its gross annual premiums for all health benefit plans issued to small employers during the previous calendar year, and also to report its gross annual premiums for new, but not renewal, standard and basic health benefit plans subject to this section issued during the previous calendar year. No later than May 1 of each year, the office shall calculate each carrier's percentage of all small employer group health premiums for the previous calendar year and shall calculate the aggregate gross annual premiums for new, but not renewal, standard and basic health benefit plans for the previous calendar year.~~

(f) ~~(j)~~ The boundaries of geographic areas used by a small employer carrier must coincide with county lines. A carrier may not apply different geographic rating factors to the rates of small employers located within the same county.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans 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 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)(f) ~~(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 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. This subparagraph does not exempt an alliance or group association from licensure for 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 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 policy term ~~reporting period~~, the carrier shall limit the application of such adjustments only to minus adjustments ~~beginning within 60 days after the report is sent to the office~~. For any subsequent policy term ~~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 "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 carrier may separate the experience of small employer groups with fewer 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. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer 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.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

~~1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.~~

1.~~2.~~ Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a

small employer may be reinsured within 60 days after the commencement of his or her coverage.

2.~~3.~~ A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. ~~The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.~~

3.~~4.~~ The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.

4.~~5.~~ The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.

5.~~6.~~ A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan

anniversary.

6.~~7.~~ The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 3. ~~4.~~, shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 3. ~~4.~~ which may not be ceded to the program.

7.~~8.~~ The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.

8.~~9.~~ A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that

reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office~~, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan~~. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:

a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.

b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the office.

(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year,

and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (m) ~~(n)~~, risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the

assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed

to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and

other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

~~(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of~~

~~compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.~~

(l) ~~(m)~~ The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.

(m) ~~(n)~~ Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state

during such calendar year.

(n) ~~(o)~~ The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.

2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.

3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.

4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.

5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

~~(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—~~

~~(a)1. The Chief Financial Officer shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The Chief Financial Officer may require the board to submit additional recommendations of individuals for appointment.~~

~~2. The plans shall comply with all of the requirements of this subsection.~~

~~3. The plans must be filed with and approved by the office prior to issuance or delivery by any small employer carrier.~~

~~4. After approval of the revised health benefit plans, if the office determines that modifications to a plan might be appropriate, the Chief Financial Officer shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the office for approval.~~

~~(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue~~

~~Service, that meet the criteria set forth in this section.~~

~~2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers that contain:~~

~~a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and~~

~~b. A procedure for preauthorization by the small employer carrier, or its designees.~~

~~3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:~~

~~a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in~~

~~group products that are not issued to small employers.~~

~~b. A procedure for utilization review by the small employer carrier or its designees.~~

~~This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.~~

~~4. The standard health benefit plan shall include:~~

~~a. Coverage for inpatient hospitalization;~~

~~b. Coverage for outpatient services;~~

~~c. Coverage for newborn children pursuant to s. 627.6575;~~

~~d. Coverage for child care supervision services pursuant to s. 627.6579;~~

~~e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;~~

~~f. Coverage for mammograms pursuant to s. 627.6613;~~

~~g. Coverage for handicapped children pursuant to s. 627.6615;~~

~~h. Emergency or urgent care out of the geographic service area; and~~

~~i. Coverage for services provided by a hospice licensed~~

~~under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.~~

~~5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.~~

~~6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.~~

~~7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.~~

~~8. The high deductible plan associated with a health savings account or a health reimbursement arrangement shall include all the benefits specified in subparagraph 4.~~

~~9. Each small employer carrier that provides for inpatient~~

~~and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.~~

~~(c) If a small employer rejects, in writing, the standard health benefit plan, the basic health benefit plan, and the high deductible health savings account plan or a health reimbursement arrangement, the small employer carrier may offer the small employer a limited benefit policy or contract.~~

~~(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for a small employer group, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:~~

~~a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;~~

~~b. An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and~~

~~c. An explanation of the primary and preventive care features of the policy or contract.~~

~~Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the~~

~~policy or certificate or evidence of coverage provided to the employer group.~~

~~2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the carrier must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:~~

~~a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;~~

~~b. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the policy or contract;~~

~~c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and~~

~~d. If a limited plan is requested, acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder rejected that coverage.~~

~~A copy of such written statement must be provided to the~~

~~prospective policyholder by the time of delivery of the policy or contract, and the original of such written statement must be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever is longer.~~

~~3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.~~

~~(c) A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the office and the office has approved it under ss. 627.410 and 627.411 and this section.~~

(12) ~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each small employer carrier shall actively market health benefit plan coverage~~, including the basic and standard health benefit plans~~, including any subsequent modifications or additions to those plans, to eligible small employers in the state. ~~Before January 1, 1994, if a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health~~

~~benefit plan and a standard health benefit plan. Beginning January 1, 1994,~~ Small employer carriers must offer and issue all plans on a guaranteed-issue basis.

(b) A ~~No~~ small employer carrier or agent shall not, directly or indirectly, engage in the following activities:

1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(c) ~~The provisions of~~ Paragraph (a) does ~~shall~~ not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(d) A ~~No~~ small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides

compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

~~(e) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health benefit plan.~~

(e)~~(f)~~ A ~~No~~ small employer carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(f)~~(g)~~ A ~~No~~ small employer carrier or agent shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(g)~~(h)~~ Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(h)~~(i)~~ The commission may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(i) ~~(j)~~ A violation of this section by a small employer carrier or an agent is ~~shall be~~ an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.

(j) ~~(k)~~ If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

(13) ~~(14)~~ DISCLOSURE OF INFORMATION.—

(a) In connection with the offering of a health benefit plan to a small employer, a small employer carrier:

1. Shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b); and

2. Upon request of the small employer, provide such information.

(b)1. Subject to subparagraph 3., with respect to a small employer carrier that offers a health benefit plan to a small employer, information described in this paragraph is information that concerns:

a. The provisions of such coverage concerning an insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of such coverage that relate to renewability of coverage;

c. The provisions of such coverage that relate to any preexisting condition exclusions; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

2. Information required under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

3. An insurer is not required under this subsection to disclose any information that is proprietary or a trade secret under state law.

(14) ~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—

(k) Benefits.—~~The benefits provided by the plan shall be the same as the coverage required for small employers under subsection (12).~~ Upon the approval of the office, the insurer may ~~also~~ establish an optional mutually supported benefit plan that ~~which~~ is an alternative plan developed within a defined geographic region of this state or any other such alternative plan that ~~which~~ will carry out the intent of this subsection. Any small employer carrier issuing new health benefit plans may offer a benefit plan with coverages similar to, but not less than, any alternative coverage plan developed pursuant to this subsection.

(15) ~~(16)~~ APPLICABILITY OF OTHER STATE LAWS.—

(a) Except as expressly provided in this section, a law

requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to ~~a standard or basic health benefit plan policy or contract or~~ a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy~~, including a standard or basic health benefit plan policy or contract,~~ offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. ~~However, every small employer carrier must offer to eligible small employers the standard benefit plan and the basic benefit plan, as required by subsection (5), as such plans have been approved by the office pursuant to subsection (12).~~

~~(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:~~

~~1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;~~

~~2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or~~

~~method of reimbursing care or services provided under a health benefit plan; or~~

~~3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.~~

(b) ~~(c)~~ Any second tier assessment paid by a carrier pursuant to paragraph (11)(j) may be credited against assessments levied against the carrier pursuant to s. 627.6494.

(c) ~~(d)~~ Notwithstanding chapter 641, a health maintenance organization may ~~is authorized to~~ issue contracts providing benefits equal to the ~~standard health benefit plan, the basic health benefit plan, and the~~ limited benefit policy authorized by this section.

(16) ~~(17)~~ RESTRICTIONS ON COVERAGE.—

(a) A plan under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion, as defined in s. 390.011(1), except if the pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician,

place the woman in danger of death unless an abortion is performed. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the plan.

(b) This subsection does not prohibit a plan from providing any person or entity with separate coverage for an abortion if such coverage is not purchased in whole or in part with state or federal funds.

(c) As used in this section, the term "state" means this state or any political subdivision of the state.

(17)~~(18)~~ RULEMAKING AUTHORITY.—The commission may adopt rules to administer this section, including rules governing compliance by small employer carriers and small employers.

Section 2. Section 627.66997, Florida Statutes, is created to read:

627.66997 Stop-loss insurance.—

(1) A self-insured health benefit plan established or maintained by a small employer, as defined in s. 627.6699(3)(v), is exempt from s. 627.6699 and may use a stop-loss insurance policy issued to the employer. For purposes of this subsection, the term "stop-loss insurance policy" means an insurance policy issued to a small employer which covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insured health benefit plan.

(a) A small employer stop-loss insurance policy is

considered a health insurance policy and is subject to s. 627.6699 if the policy has an aggregate attachment point that is lower than the greatest of:

1. Two thousand dollars multiplied by the number of employees;

2. One hundred twenty percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

3. Twenty thousand dollars.

(b) Once claims under the small employer health benefit plan reach the aggregate attachment point set forth in paragraph (a), the stop-loss insurance policy authorized under this section must cover 100 percent of all claims that exceed the aggregate attachment point.

(2) A self-insured health benefit plan established or maintained by an employer with 51 or more covered employees is considered health insurance if the plan's stop-loss coverage, as defined in s. 627.6482(14), has an aggregate attachment point that is lower than the greater of:

(a) One hundred ten percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

(b) Twenty thousand dollars.

(3) Stop-loss insurance carriers shall use a consistent basis for determining the number of an employer's covered employees. Such basis may include, but is not limited to, the

average number of employees employed annually or at a uniform time.

Section 3. 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)(k) ~~627.6699(3)(l)~~ 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 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 4. Paragraph (g) of subsection (7) and paragraph (a) of subsection (8) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.—

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers, including, but not limited to, the provisions of s. 627.6699(11) relating to:

1. Use of assessments that exceed the amount of actual losses and expenses.

2. The annual determination of each carrier's proportion of the assessment.

3. Interest for late payment of assessments.

4. Authority for the office to approve deferment of an assessment against a carrier.

5. Limited immunity from legal actions or carriers.

6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically enumerated in s. 627.6699(12)(d) ~~627.6699(13)(d)~~.

7. Monitoring compliance by carriers with this section.

(8) STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(12) ~~627.6699(13)~~ that apply to small employer carriers that market policies to small employers shall also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

Section 5. 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)(k) ~~627.6699(3)(l)~~ 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 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 6. Paragraph (e) of subsection (2) of section 627.6571, Florida Statutes, is amended to read:

627.6571 Guaranteed renewability of coverage.—

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following

conditions:

(e) In the case of an insurer that offers health insurance coverage through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the insurer or in the area in which the insurer is authorized to do business ~~and, in the case of the small-group market, the insurer would deny enrollment with respect to such plan under s. 627.6699(5)(i)~~.

Section 7. Subsection (11) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group

insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(11) ALTERNATIVE PLANS. ~~The insurer shall, in addition to the option required by subsection (10), offer the standard health benefit plan, as established pursuant to s. 627.6699(12).~~ The insurer may, at its option, ~~also~~ offer alternative plans for group health conversion in addition to the plans required by this section.

Section 8. Paragraph (e) of subsection (2) of section 641.31074, Florida Statutes, is amended to read:

641.31074 Guaranteed renewability of coverage.—

(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:

(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business ~~and, in the case of the small group market, the organization~~

~~would deny enrollment with respect to such plan under s. 627.6699(5)(i)~~.

Section 9. Subsection (10) of section 641.3922, Florida Statutes, is amended to read:

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

(10) ALTERNATE PLANS.~~—The health maintenance organization shall offer a standard health benefit plan as established pursuant to s. 627.6699(12).~~ The health maintenance organization may, at its option, ~~also~~ offer alternative plans for group health conversion in addition to those required by this section, provided any alternative plan is approved by the office or is a converted policy, approved under s. 627.6675 and issued by an insurance company authorized to transact insurance in this state. Approval by the office of an alternative plan shall be based on compliance by the alternative plan with the provisions of this part and the rules promulgated thereunder, applicable provisions of the Florida Insurance Code and rules promulgated thereunder, and any other applicable law.

Section 10. This act shall take effect July 1, 2015.