

HB 731

2015

1 A bill to be entitled

2 An act relating to employee health care plans;
3 amending s. 627.6699, F.S.; revising definitions;
4 removing provisions requiring certain insurance
5 carriers to provide semiannual reports to the Office
6 of Insurance Regulation; repealing requirements that
7 certain insurance carriers offer standard, basic, high
8 deductible, and limited health benefit plans; making
9 conforming changes; creating s. 627.66997, F.S.;

10 authorizing certain small employer insurance policies
11 to provide stop-loss coverage; providing requirements
12 for such policies; amending ss. 627.642, 627.6475, and
13 627.657, F.S.; conforming cross-references; amending
14 ss. 627.6571, 627.6675, 641.31074, and 641.3922, F.S.;

15 conforming provisions to changes made by the act;
16 providing an effective date.

17
18 Be It Enacted by the Legislature of the State of Florida:

19
20 Section 1. Subsection (2) of section 627.6699, Florida
21 Statutes, is amended, paragraphs (c) through (x) of subsection
22 (3) are redesignated as paragraphs (b) through (w),
23 respectively, and present paragraphs (b) and (o) of that
24 subsection, subsection (5), paragraph (b) of subsection (6),
25 paragraphs (g), (h), (j), and (l) through (o) of subsection
26 (11), subsections (12) through (14), paragraph (k) of subsection

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

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27 (15), and subsections (16) through (18) of that section are
 28 amended, to read:

29 627.6699 Employee Health Care Access Act.—

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

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

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

46 (n) ~~(e)~~ "Modified community rating" means a method used to
 47 develop carrier premiums which spreads financial risk across a
 48 large population; allows the use of separate rating factors for
 49 age, gender, family composition, tobacco usage, and geographic
 50 area as determined under paragraph (5) (f) ~~(5) (j)~~; and allows
 51 adjustments for: claims experience, health status, or duration
 52 of coverage as permitted under subparagraph (6) (b) 5.; and

53 administrative and acquisition expenses as permitted under
 54 subparagraph (6) (b) 5.

55 (5) AVAILABILITY OF COVERAGE.—

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

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

73 ~~(b) (e)~~ Every small employer carrier must, as a condition
 74 of transacting business in this state, ÷

75 ~~1.~~ offer and issue all small employer health benefit plans
 76 on a guaranteed-issue basis to every eligible small employer,
 77 with 2 to 50 eligible employees, that elects to be covered under
 78 such plan, agrees to make the required premium payments, and

79 satisfies the other provisions of the plan. A rider for
80 additional or increased benefits may be medically underwritten
81 and may only be added to the standard health benefit plan. The
82 increased rate charged for the additional or increased benefit
83 must be rated in accordance with this section.

84 ~~2. In the absence of enrollment availability in the~~
85 ~~Florida Health Insurance Plan, offer and issue basic and~~
86 ~~standard small employer health benefit plans and a high-~~
87 ~~deductible plan that meets the requirements of a health savings~~
88 ~~account plan or health reimbursement account as defined by~~
89 ~~federal law, on a guaranteed issue basis, during a 31-day open~~
90 ~~enrollment period of August 1 through August 31 of each year, to~~
91 ~~every eligible small employer, with fewer than two eligible~~
92 ~~employees, which small employer is not formed primarily for the~~
93 ~~purpose of buying health insurance and which elects to be~~
94 ~~covered under such plan, agrees to make the required premium~~
95 ~~payments, and satisfies the other provisions of the plan.~~
96 ~~Coverage provided under this subparagraph shall begin on October~~
97 ~~1 of the same year as the date of enrollment, unless the small~~
98 ~~employer carrier and the small employer agree to a different~~
99 ~~date. A rider for additional or increased benefits may be~~
100 ~~medically underwritten and may only be added to the standard~~
101 ~~health benefit plan. The increased rate charged for the~~
102 ~~additional or increased benefit must be rated in accordance with~~
103 ~~this section. For purposes of this subparagraph, a person, his~~
104 ~~or her spouse, and his or her dependent children constitute a~~

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

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

116 ~~(d) A small employer carrier must file with the office, in~~
117 ~~a format and manner prescribed by the committee, a standard~~
118 ~~health care plan, a high deductible plan that meets the federal~~
119 ~~requirements of a health savings account plan or a health~~
120 ~~reimbursement arrangement, and a basic health care plan to be~~
121 ~~used by the carrier. The provisions of this section requiring~~
122 ~~the filing of a high deductible plan are effective September 1,~~
123 ~~2004.~~

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

129 ~~(c)-(f)~~ Except as provided in paragraph (d) ~~(g)~~, a health
130 benefit plan covering small employers must comply with

131 preexisting condition provisions specified in s. 627.6561 or,
132 for health maintenance contracts, in s. 641.31071.

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

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

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

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

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

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

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

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

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

183 least 6 months. A small employer carrier may vary application of
184 minimum participation requirements and minimum employer
185 contribution requirements only by the size of the small employer
186 group.

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

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

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

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

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

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

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

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

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

235 ~~2. A small employer carrier that cannot offer coverage~~
 236 ~~pursuant to sub-subparagraph 1.c. may not offer coverage in the~~
 237 ~~applicable area to new cases of employer groups having more than~~
 238 ~~50 eligible employees or small employer groups until the later~~
 239 ~~of 180 days following each such refusal or the date on which the~~
 240 ~~carrier notifies the office that it has regained its ability to~~
 241 ~~deliver services to small employer groups.~~

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

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

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

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

261 ~~for the application of this sub-subparagraph on a service-area-~~
 262 ~~specific basis.~~

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

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

279 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

284 1. Small employer carriers must use a modified community
 285 rating methodology in which the premium for each small employer
 286 is determined solely on the basis of the eligible employee's and

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287 eligible dependent's gender, age, family composition, tobacco
288 use, or geographic area as determined under paragraph (5) (f)
289 ~~(5) (j)~~ and in which the premium may be adjusted as permitted by
290 this paragraph. A small employer carrier is not required to use
291 gender as a rating factor for a nongrandfathered health plan.

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

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

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

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

311 4. A carrier may issue a group health insurance policy to
312 a small employer health alliance or other group association with

313 rates that reflect a premium credit for expense savings
314 attributable to administrative activities being performed by the
315 alliance or group association if such expense savings are
316 specifically documented in the insurer's rate filing and are
317 approved by the office. Any such credit may not be based on
318 different morbidity assumptions or on any other factor related
319 to the health status or claims experience of any person covered
320 under the policy. This subparagraph does not exempt an alliance
321 or group association from licensure for activities that require
322 licensure under the insurance code. A carrier issuing a group
323 health insurance policy to a small employer health alliance or
324 other group association shall allow any properly licensed and
325 appointed agent of that carrier to market and sell the small
326 employer health alliance or other group association policy. Such
327 agent shall be paid the usual and customary commission paid to
328 any agent selling the policy.

329 5. Any adjustments in rates for claims experience, health
330 status, or duration of coverage may not be charged to individual
331 employees or dependents. For a small employer's policy, such
332 adjustments may not result in a rate for the small employer
333 which deviates more than 15 percent from the carrier's approved
334 rate. Any such adjustment must be applied uniformly to the rates
335 charged for all employees and dependents of the small employer.
336 A small employer carrier may make an adjustment to a small
337 employer's renewal premium, up to 10 percent annually, due to
338 the claims experience, health status, or duration of coverage of

339 the employees or dependents of the small employer. ~~Semiannually,~~
340 ~~small group carriers shall report information on forms adopted~~
341 ~~by rule by the commission, to enable the office to monitor the~~
342 ~~relationship of aggregate adjusted premiums actually charged~~
343 ~~policyholders by each carrier to the premiums that would have~~
344 ~~been charged by application of the carrier's approved modified~~
345 ~~community rates.~~ If the aggregate resulting from the application
346 of such adjustment exceeds the premium that would have been
347 charged by application of the approved modified community rate
348 by 4 percent for the current policy term reporting period, the
349 carrier shall limit the application of such adjustments only to
350 minus adjustments ~~beginning within 60 days after the report is~~
351 ~~sent to the office.~~ For any subsequent policy term reporting
352 period, if the total aggregate adjusted premium actually charged
353 does not exceed the premium that would have been charged by
354 application of the approved modified community rate by 4
355 percent, the carrier may apply both plus and minus adjustments.
356 A small employer carrier may provide a credit to a small
357 employer's premium based on administrative and acquisition
358 expense differences resulting from the size of the group. Group
359 size administrative and acquisition expense factors may be
360 developed by each carrier to reflect the carrier's experience
361 and are subject to office review and approval.

362 6. A small employer carrier rating methodology may include
363 separate rating categories for one dependent child, for two
364 dependent children, and for three or more dependent children for

365 family coverage of employees having a spouse and dependent
366 children or employees having dependent children only. A small
367 employer carrier may have fewer, but not greater, numbers of
368 categories for dependent children than those specified in this
369 subparagraph.

370 7. Small employer carriers may not use a composite rating
371 methodology to rate a small employer with fewer than 10
372 employees. For the purposes of this subparagraph, the term
373 "composite rating methodology" means a rating methodology that
374 averages the impact of the rating factors for age and gender in
375 the premiums charged to all of the employees of a small
376 employer.

377 8. A carrier may separate the experience of small employer
378 groups with fewer than 2 eligible employees from the experience
379 of small employer groups with 2-50 eligible employees for
380 purposes of determining an alternative modified community
381 rating.

382 a. If a carrier separates the experience of small employer
383 groups, the rate to be charged to small employer groups of fewer
384 than 2 eligible employees may not exceed 150 percent of the rate
385 determined for small employer groups of 2-50 eligible employees.
386 However, the carrier may charge excess losses of the experience
387 pool consisting of small employer groups with less than 2
388 eligible employees to the experience pool consisting of small
389 employer groups with 2-50 eligible employees so that all losses
390 are allocated and the 150-percent rate limit on the experience

391 pool consisting of small employer groups with less than 2
392 eligible employees is maintained.

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

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

402 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

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

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

412 1.2. Except in the case of a late enrollee, a reinsuring
413 carrier may reinsure an eligible employee or dependent within 60
414 days after the commencement of the coverage of the small
415 employer. A newly employed eligible employee or dependent of a
416 small employer may be reinsured within 60 days after the

417 commencement of his or her coverage.

418 ~~2.3.~~ A small employer carrier may reinsure an entire
419 employer group within 60 days after the commencement of the
420 group's coverage under the plan. ~~The carrier may choose to~~
421 ~~reinsure newly eligible employees and dependents of the~~
422 ~~reinsured group pursuant to subparagraph 1.~~

423 3.4. The program may not reimburse a participating carrier
424 with respect to the claims of a reinsured employee or dependent
425 until the carrier has paid incurred claims of at least \$5,000 in
426 a calendar year for benefits covered by the program. In
427 addition, the reinsuring carrier shall be responsible for 10
428 percent of the next \$50,000 and 5 percent of the next \$100,000
429 of incurred claims during a calendar year and the program shall
430 reinsure the remainder.

431 4.5. The board annually shall adjust the initial level of
432 claims and the maximum limit to be retained by the carrier to
433 reflect increases in costs and utilization within the standard
434 market for health benefit plans within the state. The adjustment
435 shall not be less than the annual change in the medical
436 component of the "Consumer Price Index for All Urban Consumers"
437 of the Bureau of Labor Statistics of the Department of Labor,
438 unless the board proposes and the office approves a lower
439 adjustment factor.

440 ~~5.6.~~ A small employer carrier may terminate reinsurance
441 for all reinsured employees or dependents on any plan
442 anniversary.

443 ~~6.7.~~ The premium rate charged for reinsurance by the
444 program to a health maintenance organization that is approved by
445 the Secretary of Health and Human Services as a federally
446 qualified health maintenance organization pursuant to 42 U.S.C.
447 s. 300e(c)(2)(A) and that, as such, is subject to requirements
448 that limit the amount of risk that may be ceded to the program,
449 which requirements are more restrictive than subparagraph 3. 4.,
450 shall be reduced by an amount equal to that portion of the risk,
451 if any, which exceeds the amount set forth in subparagraph 3. 4.
452 which may not be ceded to the program.

453 ~~7.8.~~ The board may consider adjustments to the premium
454 rates charged for reinsurance by the program for carriers that
455 use effective cost containment measures, including high-cost
456 case management, as defined by the board.

457 8.9. A reinsuring carrier shall apply its case-management
458 and claims-handling techniques, including, but not limited to,
459 utilization review, individual case management, preferred
460 provider provisions, other managed care provisions or methods of
461 operation, consistently with both reinsured business and
462 nonreinsured business.

463 (h)1. The board, as part of the plan of operation, shall
464 establish a methodology for determining premium rates to be
465 charged by the program for reinsuring small employers and
466 individuals pursuant to this section. The methodology shall
467 include a system for classification of small employers that
468 reflects the types of case characteristics commonly used by

469 small employer carriers in the state. The methodology shall
470 provide for the development of basic reinsurance premium rates,
471 which shall be multiplied by the factors set for them in this
472 paragraph to determine the premium rates for the program. The
473 basic reinsurance premium rates shall be established by the
474 board, subject to the approval of the office, ~~and shall be set~~
475 ~~at levels which reasonably approximate gross premiums charged to~~
476 ~~small employers by small employer carriers for health benefit~~
477 ~~plans with benefits similar to the standard and basic health~~
478 ~~benefit plan.~~ The premium rates set by the board may vary by
479 geographical area, as determined under this section, to reflect
480 differences in cost. The multiplying factors must be established
481 as follows:

482 a. The entire group may be reinsured for a rate that is
483 1.5 times the rate established by the board.

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

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

491 (j)1. Before July 1 of each calendar year, the board shall
492 determine and report to the office the program net loss for the
493 previous year, including administrative expenses for that year,
494 and the incurred losses for the year, taking into account

495 investment income and other appropriate gains and losses.

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

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

512 b. The board shall equitably assess carriers for operating
513 losses of the plan based on market share. The board shall
514 annually assess each carrier a portion of the operating losses
515 of the plan. The first tier of assessments shall be determined
516 by multiplying the operating losses by a fraction, the numerator
517 of which equals the reinsuring carrier's earned premium
518 pertaining to direct writings of small employer health benefit
519 plans in the state during the calendar year for which the
520 assessment is levied, and the denominator of which equals the

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

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

544 3. Before July 1 of each year, the board shall determine
545 and file with the office an estimate of the assessments needed
546 to fund the losses incurred by the program in the previous

547 calendar year.

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

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

570 6. Each carrier's proportion of the assessment shall be
571 determined annually by the board, based on annual statements and
572 other reports considered necessary by the board and filed by the

573 carriers with the board.

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

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

590 ~~(1) The board, as part of the plan of operation, shall~~
591 ~~develop standards setting forth the manner and levels of~~
592 ~~compensation to be paid to agents for the sale of basic and~~
593 ~~standard health benefit plans. In establishing such standards,~~
594 ~~the board shall take into consideration the need to assure the~~
595 ~~broad availability of coverages, the objectives of the program,~~
596 ~~the time and effort expended in placing the coverage, the need~~
597 ~~to provide ongoing service to the small employer, the levels of~~
598 ~~compensation currently used in the industry, and the overall~~

599 ~~costs of coverage to small employers selecting these plans.~~

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

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

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

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

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

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

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

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

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

650 ~~(a)1. The Chief Financial Officer shall appoint a health~~

651 ~~benefit plan committee composed of four representatives of~~
652 ~~carriers which shall include at least two representatives of~~
653 ~~HMOs, at least one of which is a staff model HMO, two~~
654 ~~representatives of agents, four representatives of small~~
655 ~~employers, and one employee of a small employer. The carrier~~
656 ~~members shall be selected from a list of individuals recommended~~
657 ~~by the board. The Chief Financial Officer may require the board~~
658 ~~to submit additional recommendations of individuals for~~
659 ~~appointment.~~

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

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

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

670 ~~(b)1. Each small employer carrier issuing new health~~
671 ~~benefit plans shall offer to any small employer, upon request, a~~
672 ~~standard health benefit plan, a basic health benefit plan, and a~~
673 ~~high deductible plan that meets the requirements of a health~~
674 ~~savings account plan as defined by federal law or a health~~
675 ~~reimbursement arrangement as authorized by the Internal Revenue~~
676 ~~Service, that meet the criteria set forth in this section.~~

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

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

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

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

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

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

705
706 ~~This subparagraph does not prohibit a small employer carrier~~
707 ~~from including in its policy or contract additional managed care~~
708 ~~and cost containment provisions, subject to the approval of the~~
709 ~~office, which have potential for controlling costs in a manner~~
710 ~~that does not result in inequitable treatment of insureds or~~
711 ~~subscribers. The carrier may use such provisions to the same~~
712 ~~extent as authorized for group products that are not issued to~~
713 ~~small employers.~~

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

715 ~~a. Coverage for inpatient hospitalization;~~

716 ~~b. Coverage for outpatient services;~~

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

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

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

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

723 ~~g. Coverage for handicapped children pursuant to s.~~
724 ~~627.6615;~~

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

727 ~~i. Coverage for services provided by a hospice licensed~~
728 ~~under s. 400.602 in cases where such coverage would be the most~~

729 ~~appropriate and the most cost-effective method for treating a~~
730 ~~covered illness.~~

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

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

743 ~~7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612,~~
744 ~~627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911~~
745 ~~apply to the standard health benefit plan and to the basic~~
746 ~~health benefit plan. However, notwithstanding said provisions,~~
747 ~~the plans may specify limits on the number of authorized~~
748 ~~treatments, if such limits are reasonable and do not~~
749 ~~discriminate against any type of provider.~~

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

753 ~~9. Each small employer carrier that provides for inpatient~~
754 ~~and outpatient services by allopathic hospitals may provide as~~

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

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

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

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

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

775 ~~e. An explanation of the primary and preventive care~~
776 ~~features of the policy or contract.~~

777

778 ~~Such disclosure statement must be presented in a clear and~~
779 ~~understandable form and format and must be separate from the~~
780 ~~policy or certificate or evidence of coverage provided to the~~

781 ~~employer group.~~

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

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

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

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

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

804
805 ~~A copy of such written statement must be provided to the~~
806 ~~prospective policyholder by the time of delivery of the policy~~

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

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

815 ~~(c) A small employer carrier may not use any policy,~~
816 ~~contract, form, or rate under this section, including~~
817 ~~applications, enrollment forms, policies, contracts,~~
818 ~~certificates, evidences of coverage, riders, amendments,~~
819 ~~endorsements, and disclosure forms, until the insurer has filed~~
820 ~~it with the office and the office has approved it under ss.~~
821 ~~627.410 and 627.411 and this section.~~

822 (12) ~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—

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

833 ~~January 1, 1994,~~ Small employer carriers must offer and issue
 834 all plans on a guaranteed-issue basis.

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

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

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

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

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

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859 provided that the percentage shall not vary because of the
860 health status, claims experience, industry, occupation, or
861 geographic area of the small employer.

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

866 (e)~~(f)~~ A ~~Ne~~ small employer carrier shall not terminate,
867 fail to renew, or limit its contract or agreement of
868 representation with an agent for any reason related to the
869 health status, claims experience, occupation, or geographic
870 location of the small employers placed by the agent with the
871 small employer carrier unless the agent consistently engages in
872 practices that violate this section or s. 626.9541.

873 (f)~~(g)~~ A ~~Ne~~ small employer carrier or agent shall not
874 induce or otherwise encourage a small employer to separate or
875 otherwise exclude an employee from health coverage or benefits
876 provided in connection with the employee's employment.

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

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

884 (i)~~(j)~~ A violation of this section by a small employer

885 carrier or an agent is ~~shall be~~ an unfair trade practice under
 886 s. 626.9541 or ss. 641.3903 and 641.3907.

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

893 (13) ~~(14)~~ DISCLOSURE OF INFORMATION.—

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

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

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

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

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

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

910 c. The provisions of such coverage that relate to any

911 preexisting condition exclusions; and

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

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

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

922 (14) ~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—

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

934 (15) ~~(16)~~ APPLICABILITY OF OTHER STATE LAWS.—

935 (a) Except as expressly provided in this section, a law
936 requiring coverage for a specific health care service or

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

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

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

960 ~~2. Imposes any restriction on a small employer carrier's~~
961 ~~ability to negotiate with providers regarding the level or~~
962 ~~method of reimbursing care or services provided under a health~~

963 ~~benefit plan; or~~

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

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

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

977 ~~(16)(17)~~ RESTRICTIONS ON COVERAGE.—

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

989 performed. Coverage is deemed to be purchased with state or
 990 federal funds if any tax credit or cost-sharing credit is
 991 applied toward the plan.

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

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

998 ~~(17)-(18)~~ RULEMAKING AUTHORITY.—The commission may adopt
 999 rules to administer this section, including rules governing
 1000 compliance by small employer carriers and small employers.

1001 Section 2. Section 627.66997, Florida Statutes, is created
 1002 to read:

1003 627.66997 Stop-loss insurance.—

1004 (1) A plan established or maintained by an individual
 1005 small employer in accordance with the Employee Retirement Income
 1006 Security Act of 1974 (ERISA), Pub. L. No. 93-406, may provide a
 1007 policy of stop-loss coverage, as defined in s. 627.6482, in lieu
 1008 of the requirements of s. 627.6699 if the policy has an
 1009 aggregate attachment point that is lower than the greatest of:

- 1010 (a) Two thousand dollars times the number of employees;
- 1011 (b) One hundred twenty percent of expected claims; or
- 1012 (c) Ten thousand dollars.

1013 (2) Health insurance providers shall use a consistent
 1014 method of determining the number of covered employees of an

1015 employer. Such method may include, but is not limited to, the
 1016 average number of employees employed on an annual basis or the
 1017 number of employees employed on a uniform annual date.

1018 Section 3. Subsection (3) of section 627.642, Florida
 1019 Statutes, is amended to read:

1020 627.642 Outline of coverage.—

1021 (3) In addition to the outline of coverage, a policy as
 1022 specified in s. 627.6699(3)(k) ~~627.6699(3)(1)~~ must be
 1023 accompanied by an identification card that contains, at a
 1024 minimum:

1025 (a) The name of the organization issuing the policy or the
 1026 name of the organization administering the policy, whichever
 1027 applies.

1028 (b) The name of the contract holder.

1029 (c) The type of plan only if the plan is filed in the
 1030 state, an indication that the plan is self-funded, or the name
 1031 of the network.

1032 (d) The member identification number, contract number, and
 1033 policy or group number, if applicable.

1034 (e) A contact phone number or electronic address for
 1035 authorizations and admission certifications.

1036 (f) A phone number or electronic address whereby the
 1037 covered person or hospital, physician, or other person rendering
 1038 services covered by the policy may obtain benefits verification
 1039 and information in order to estimate patient financial
 1040 responsibility, in compliance with privacy rules under the

1041 Health Insurance Portability and Accountability Act.

1042 (g) The national plan identifier, in accordance with the
 1043 compliance date set forth by the federal Department of Health
 1044 and Human Services.

1045
 1046 The identification card must present the information in a
 1047 readily identifiable manner or, alternatively, the information
 1048 may be embedded on the card and available through magnetic
 1049 stripe or smart card. The information may also be provided
 1050 through other electronic technology.

1051 Section 4. Paragraph (g) of subsection (7) and paragraph
 1052 (a) of subsection (8) of section 627.6475, Florida Statutes, are
 1053 amended to read:

1054 627.6475 Individual reinsurance pool.—

1055 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

1056 (g) Except as otherwise provided in this section, the
 1057 board and the office shall have all powers, duties, and
 1058 responsibilities with respect to carriers that issue and
 1059 reinsure individual health insurance, as specified for the board
 1060 and the office in s. 627.6699(11) with respect to small employer
 1061 carriers, including, but not limited to, the provisions of s.
 1062 627.6699(11) relating to:

1063 1. Use of assessments that exceed the amount of actual
 1064 losses and expenses.

1065 2. The annual determination of each carrier's proportion
 1066 of the assessment.

- 1067 3. Interest for late payment of assessments.
- 1068 4. Authority for the office to approve deferment of an
1069 assessment against a carrier.
- 1070 5. Limited immunity from legal actions or carriers.
- 1071 6. Development of standards for compensation to be paid to
1072 agents. Such standards shall be limited to those specifically
1073 enumerated in s. 627.6699(12)(d) ~~627.6699(13)(d)~~.
- 1074 7. Monitoring compliance by carriers with this section.
- 1075 (8) STANDARDS TO ASSURE FAIR MARKETING.—
- 1076 (a) Each health insurance issuer that offers individual
1077 health insurance shall actively market coverage to eligible
1078 individuals in the state. The provisions of s. 627.6699(12)
1079 ~~627.6699(13)~~ that apply to small employer carriers that market
1080 policies to small employers shall also apply to health insurance
1081 issuers that offer individual health insurance with respect to
1082 marketing policies to individuals.
- 1083 Section 5. Subsection (2) of section 627.657, Florida
1084 Statutes, is amended to read:
- 1085 627.657 Provisions of group health insurance policies.—
- 1086 (2) The medical policy as specified in s. 627.6699(3)(k)
1087 ~~627.6699(3)(l)~~ must be accompanied by an identification card
1088 that contains, at a minimum:
- 1089 (a) The name of the organization issuing the policy or
1090 name of the organization administering the policy, whichever
1091 applies.
- 1092 (b) The name of the certificateholder.

1093 (c) The type of plan only if the plan is filed in the
 1094 state, an indication that the plan is self-funded, or the name
 1095 of the network.

1096 (d) The member identification number, contract number, and
 1097 policy or group number, if applicable.

1098 (e) A contact phone number or electronic address for
 1099 authorizations and admission certifications.

1100 (f) A phone number or electronic address whereby the
 1101 covered person or hospital, physician, or other person rendering
 1102 services covered by the policy may obtain benefits verification
 1103 and information in order to estimate patient financial
 1104 responsibility, in compliance with privacy rules under the
 1105 Health Insurance Portability and Accountability Act.

1106 (g) The national plan identifier, in accordance with the
 1107 compliance date set forth by the federal Department of Health
 1108 and Human Services.

1109
 1110 The identification card must present the information in a
 1111 readily identifiable manner or, alternatively, the information
 1112 may be embedded on the card and available through magnetic
 1113 stripe or smart card. The information may also be provided
 1114 through other electronic technology.

1115 Section 6. Paragraph (e) of subsection (2) of section
 1116 627.6571, Florida Statutes, is amended to read:

1117 627.6571 Guaranteed renewability of coverage.—

1118 (2) An insurer may nonrenew or discontinue a group health

1119 insurance policy based only on one or more of the following
 1120 conditions:

1121 (e) In the case of an insurer that offers health insurance
 1122 coverage through a network plan, there is no longer any enrollee
 1123 in connection with such plan who lives, resides, or works in the
 1124 service area of the insurer or in the area in which the insurer
 1125 is authorized to do business ~~and, in the case of the small-group~~
 1126 ~~market, the insurer would deny enrollment with respect to such~~
 1127 ~~plan under s. 627.6699(5)(i).~~

1128 Section 7. Subsection (11) of section 627.6675, Florida
 1129 Statutes, is amended to read:

1130 627.6675 Conversion on termination of eligibility.—Subject
 1131 to all of the provisions of this section, a group policy
 1132 delivered or issued for delivery in this state by an insurer or
 1133 nonprofit health care services plan that provides, on an
 1134 expense-incurred basis, hospital, surgical, or major medical
 1135 expense insurance, or any combination of these coverages, shall
 1136 provide that an employee or member whose insurance under the
 1137 group policy has been terminated for any reason, including
 1138 discontinuance of the group policy in its entirety or with
 1139 respect to an insured class, and who has been continuously
 1140 insured under the group policy, and under any group policy
 1141 providing similar benefits that the terminated group policy
 1142 replaced, for at least 3 months immediately prior to
 1143 termination, shall be entitled to have issued to him or her by
 1144 the insurer a policy or certificate of health insurance,

1145 referred to in this section as a "converted policy." A group
 1146 insurer may meet the requirements of this section by contracting
 1147 with another insurer, authorized in this state, to issue an
 1148 individual converted policy, which policy has been approved by
 1149 the office under s. 627.410. An employee or member shall not be
 1150 entitled to a converted policy if termination of his or her
 1151 insurance under the group policy occurred because he or she
 1152 failed to pay any required contribution, or because any
 1153 discontinued group coverage was replaced by similar group
 1154 coverage within 31 days after discontinuance.

1155 (11) ALTERNATIVE PLANS. ~~The insurer shall, in addition to~~
 1156 ~~the option required by subsection (10), offer the standard~~
 1157 ~~health benefit plan, as established pursuant to s. 627.6699(12).~~
 1158 The insurer may, at its option, ~~also~~ offer alternative plans for
 1159 group health conversion in addition to the plans required by
 1160 this section.

1161 Section 8. Paragraph (e) of subsection (2) of section
 1162 641.31074, Florida Statutes, is amended to read:

1163 641.31074 Guaranteed renewability of coverage.—

1164 (2) A health maintenance organization may nonrenew or
 1165 discontinue a contract based only on one or more of the
 1166 following conditions:

1167 (e) There is no longer any enrollee in connection with
 1168 such plan who lives, resides, or works in the service area of
 1169 the health maintenance organization or in the area in which the
 1170 health maintenance organization is authorized to do business

1171 ~~and, in the case of the small group market, the organization~~
 1172 ~~would deny enrollment with respect to such plan under s.~~
 1173 ~~627.6699(5)(i).~~

1174 Section 9. Subsection (10) of section 641.3922, Florida
 1175 Statutes, is amended to read:

1176 641.3922 Conversion contracts; conditions.—Issuance of a
 1177 converted contract shall be subject to the following conditions:

1178 (10) ALTERNATE PLANS.—~~The health maintenance organization~~
 1179 ~~shall offer a standard health benefit plan as established~~
 1180 ~~pursuant to s. 627.6699(12).~~ The health maintenance organization
 1181 may, at its option, ~~also~~ offer alternative plans for group
 1182 health conversion in addition to those required by this section,
 1183 provided any alternative plan is approved by the office or is a
 1184 converted policy, approved under s. 627.6675 and issued by an
 1185 insurance company authorized to transact insurance in this
 1186 state. Approval by the office of an alternative plan shall be
 1187 based on compliance by the alternative plan with the provisions
 1188 of this part and the rules promulgated thereunder, applicable
 1189 provisions of the Florida Insurance Code and rules promulgated
 1190 thereunder, and any other applicable law.

1191 Section 10. This act shall take effect July 1, 2015.