

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
<p>1. “Grandfathered” Insurance Products – Effective: Date of enactment -- (March 23, 2010)</p>	<p>All coverage in place on the date of enactment. PPACA Sec. 1251</p>	<p>Updated by Health and Human Services (HHS): The update allows fully-insured group health plans to retain their grandfathered status if they replace existing coverage with a new policy, so long as the terms of the new policy do not violate any of the tests which would cause an existing plan to lose grandfathered status.</p>	<p>FL Insurance Code</p> <ul style="list-style-type: none"> Does not recognize “grandfathered” insurance plans for purposes of review or regulation 	
<p>2. Web portal to identify affordable coverage options Effective: July 1, 2010</p>	<p>Individual Small Group Plans PPACA Sec. 1103</p>	<p>Note/NAIC Carriers and state regulators required to file information with HHS to facilitate consumer shopping for health insurance products by state of residence</p>	<p>FL Insurance Code</p> <ul style="list-style-type: none"> No FL Insurance Code requirement to provide OIR with information filed by carriers for healthcare.gov website display. 	<p>Health Insurance Oversight System (HIOS):</p> <ul style="list-style-type: none"> Generally, it is unclear if FL OIR has unrestricted access to all information filed through the HIOS system by carriers authorized to transact insurance in FL – which includes plan details, rates, etc. Confidentiality is preserved at federal level. A Memorandum of Understanding (MOU) between the National Association of Insurance Commissioners (NAIC) and HHS for data access from the HIOS site, does not extend to the States. In Florida, should an MOU be proposed, there may be additional consideration needed with respect to the application of the State’s open records laws and resulting public records requests.

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<p>3. Temporary high risk pool program</p> <p>Effective: 90 days after enactment</p> <p><i>Floridians eligible for PCIP effective August 1, 2010</i></p>	<p>PPACA Sec. 1101</p>	<p>HHS has established a temporary high risk health insurance pool program. \$5 billion allocated to fund pools through 2013.</p> <p>The Federal Pre-Existing Condition Insurance Plan (PCIP) program is designed to sunset by 2015</p> <p>10,109 Floridians are enrolled in PCIP as of January 2013.</p> <p>In 2014, Floridians enrolled in the Federal PCIP program will be eligible for individual policies offered through a Florida Exchange or for an individual qualified health plan (QHP) offered in the individual market</p>	<p>FL Insurance Code</p> <p>In 1982, at s. 627.648 - s.627-6498, Florida created a high risk pool – the Florida Comprehensive Health Association (FCHA).</p> <p>The Association has been closed to new entrants since 1992.</p>	<ul style="list-style-type: none"> • FL current high risk pool closed since 1992 (FCHA –s. 627.648-s. 627.6498) <p>Note:</p> <ol style="list-style-type: none"> 1. In 2006, legislation created the Florida Health Insurance Plan (FHP) in s.627.64872, et.seq. designed to redesign a high risk pool for Floridians. However that plan was not made operational. 2. At present, there are still policyholders covered under the terms and conditions of the original high risk pool – the FCHA. <p>It is unclear if the FCHA would be considered a “grandfathered” plan for purposes of PPACA compliance.</p>

Effective for Plan Years beginning on or after September 23, 2010

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<p>4. Preexisting condition exclusions (Children)</p>	<p>All plans except grandfathered individual market plans</p> <p>PPACA Sec. 1201 & 10103(e) /PHSA 2704</p>	<p>A plan may not impose any preexisting condition exclusions for children under age 19.</p>	<p>FL Insurance Code</p> <p>s. 627.6045, 627.6561, and 641.31(16)</p>	<p>Carriers offering “child only” health policies ceased new writing in 2010;</p>
<p>5. Rescissions</p>	<p>All plans</p> <p>PPACA Sec. 1001 /PHSA 2712</p>	<p>Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage.</p> <p>Notification must be made to policyholders prior to cancellation (30 days).</p>	<p>FL Insurance Code</p> <p>Generally, s. 626.9541(1)(g)3. -- unfair discrimination</p> <p>s.627.607 allows rescission up to 2 years. After 2 years only for fraud</p>	<p>In addition – HHS Regulation calls for 30 day notice for cancellation – FL requires 45/10 day notice periods for non-payment of premium cancellation at s. 627.6043</p>
<p>6. Annual Limits</p>	<p>Annual limits: All plans except grandfathered individual market plans</p> <p>PPACA Sec. 1001/ PHSA 2711</p>	<p>No annual limits for essential health benefits.</p> <ul style="list-style-type: none"> Annual limits on essential benefits are limited to \$2 million for plan years beginning 9/23/2012-12/31/2013 	<p>FL Insurance Code</p> <p>No FL law specifies annual policy limits for a comprehensive health insurance policy or regulated health plan.</p>	<p>In FL law, there are annual limits set for some mandated benefits and/or mandated offers of coverage: Examples include:</p> <ul style="list-style-type: none"> Autism -- \$36,000 per year (s. 627.6686 and s.641.31098) Home health services, no less than \$1,000 per year (s. 627.6617): Substance abuse – maximum of 44 outpatient visits at a max of \$35/per outpatient visit (s.627.669)

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<p>7. Lifetime Limits</p>	<p>Lifetime limits: All plans</p> <p>PPACA Sec. 1001/ PHSA 2711</p>	<ul style="list-style-type: none"> Plans may not establish lifetime limits <i>on the dollar value of essential benefits</i>. Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS (Waiver program for carriers, employers to seek waivers for “mini-med” plans was made operational in 2010) 	<p>FL Insurance Code</p> <p>Current law/rules are silent regarding allowable annual or lifetime dollar limits.</p>	<p>Florida law on autism benefit does establish annual and lifetime limits: -- annual dollar limit in current FL law for autism benefits (\$200,000 lifetime) may be pre-empted if autism treatments are considered an essential medical/mental health benefit</p> <ul style="list-style-type: none"> This \$200,000 limit is indexed to the medical component of the consumer price index <ul style="list-style-type: none"> Current law does not define essential benefits
<p>8. Coverage of preventive health services</p> <p>As of August 1, 2012 – List of Preventive Services exempt from cost-sharing requirements http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html</p>	<p>All non-grandfathered plans</p> <p>PPACA Sec. 1001 /PHSA 2713</p>	<p>Plans must provide coverage without cost-sharing for specified preventive services, screenings, and immunizations.</p> <p>Plans that have a network of providers may impose cost-sharing for preventive items and services delivered by out-of-network providers.</p> <ul style="list-style-type: none"> Using reasonable medical management, plans may determine frequency, timing, method, treatment or setting of services to the extent not specified by HHS. A plan may impose cost-sharing for a treatment not described in the regulations, even if that treatment results from an item or service that is a covered preventive service. 	<p>FL Insurance Code</p> <p>Current law/rules are generally silent regarding what constitutes a “preventive” service or limits/prohibitions on cost-sharing for such benefits</p>	<p>There are certain provisions within the Insurance Code that would need to be amended to align with HHS Rules. Some examples:</p> <p>Autism -- behavior assessments (627.6686 and /641.31098) Child has to be diagnosed as having a developmental disability at 8 years of age or younger (HHS Regulation: up to age 17)</p> <p>Child Health Supervision s. 627.6416, 627.6579; 641.31(30). -- (Immunizations, hearing, vision testing, etc.) in compliance with standards of <i>American Academy of Pediatrics</i> – (HHS: Preventive care and services ...supported by the <i>Health Resources and Services Administration (HERSA)</i></p> <p>Mammograms –baseline, frequency by age groups (s.627.6418, 627.6613, 641.31095)</p> <p>Well-woman” care– s.627.6472(18), 627.662(9), 641.51(11), et.al.</p> <p>Osteoporosis Diagnosis—627.6409, 627.6691, 641.31(27)</p>

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<p>9. Extension of adult dependent coverage</p>	<p>All plans PPACA Sec. 1001 HR 4872 §2301 /PHSA 2714</p>	<p>Plans that provide dependent coverage must make coverage available to adult children up to age 26.</p> <ul style="list-style-type: none"> • Carriers are not required to cover children of adult dependents. • For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage. 	<p>FL Insurance Code</p> <p>At s.627.6562(1) the statute defining dependent coverage, FL law requires coverage up to the end of the calendar year in which the child reaches age 25 but with restrictions (must be unmarried without dependents of his/her own and must be resident or full-or part-time student, and is not eligible for other coverage;</p>	<ul style="list-style-type: none"> • For up to age 26, federal law is less restrictive than FL law and thus may preempt FL law restrictions applicable to dependents under age 26. • At ss.627.602(c), 627.6562, 641.31(41): Under these same restrictions, coverage must be <i>offered</i> up to age 30. <ul style="list-style-type: none"> ○ Thus, FL would appear able to enforce its restrictions on the offer of coverage from age 26-30.
<p>10. Provision of additional information</p>	<p>All non-grandfathered plans PPACA Sec. 1001 /PHSA 2715A</p>	<p>All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language:</p> <ul style="list-style-type: none"> • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage <p>Other information as determined appropriate by the Secretary</p>	<p>FL Insurance Code</p> <p>There is no provision in FL Insurance Code to require disclosure of all of these items in a “single location” posting and/or disclosure document.</p>	

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<p>11. Appeals process – Internal and External Review Standards</p>	<p>All non-grandfathered plans</p> <p>PPACA Sec. 1001 /PHSA 2719</p>	<p>Internal claims appeal process:</p> <ul style="list-style-type: none"> Group plans must incorporate the US Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. <p>External review:</p> <ul style="list-style-type: none"> All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Model Act 	<p>FL Insurance Code</p>	<p>In 2012, in SB 730, by amendment to s. 627.602 and by creation of s. 627.6513, required FL policies to comply with 29 CFR s. 2560.503-1 relating to internal grievances.</p> <ul style="list-style-type: none"> However, 29 CFR 2560. 503-1 governs only claims handling of adverse result claims. This specific Federal Regulation does NOT contain the requirements or standards for internal (or external) claims review. It is 29 CFR 2590.715-2719 that actually sets forth the standards for internal (and external) review programs. Further, the SB 730 amendments did not speak to incorporation of external review requirements for health insurance plans governed under Ch. 627 (indemnity plans). <p>SB 730 did permit the OIR to promulgate rules to adopt the NAIC Model regulation OIR is currently drafting the HMO rule to adopt NAIC Model Act and Regulations for External Review to be made applicable to HMOs governed under the provisions of Ch. 641</p>
<p>12. Patient Protections Emergency Services</p>	<p>All non-grandfathered plans</p> <p>PPACA Sec. 1001 /PHSA 2719A</p>	<p>Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.</p>	<p>FL Insurance Code</p> <p>FL law makes HMO emergency services coverage subject to similar standards at s. 641.513(3) and 641.31(2) governing HMOs.</p>	<p>FL law does not contain standards of emergency care coverage for health insurance plans governed by Ch. 627.</p> <p>Florida law governing emergency service coverage for HMOs would need to be aligned with HHS Rules and similar requirements would need to be amended into Ch. 627, to govern health insurance plans.</p>

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<p>13. Patient Protections</p> <p>Primary Care Provider</p> <p>Access to OB-GYN services</p>	<p>All non-grandfathered plans</p> <p>PPACA Sec. 1001 /PHSA 2719A</p>	<p>Primary Care Provider A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians.</p> <p>Access to OB-GYN services A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.</p>	<p>FL Insurance Code</p> <p><i>Primary Care Providers</i> FL law makes a requirement for primary care physicians for HMOs at 641.19(13)(e).</p> <p><i>Access to OB-GYN Services</i> s. 641.19(13)(e): Requires HMOs, small group HMOs to permit a female subscriber to select an OB-GYN as her primary care provider – thus no referral authorization would be required.</p>	<p>Primary Care Provider -- FL law does make the primary care physician requirement applicable to individual, large group, or small group indemnity plans governed under Ch. 627</p> <p>Access to OB-GYN Services -- FL law does not make the access to OB-GYN services requirement applicable to individual, large group, or small group indemnity plans governed under Ch. 627</p>

Effective January 1, 2011

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<p>14. Medical Loss Ratios (MLR)</p>	<p>All fully insured plans, including grandfathered plans</p> <p>PPACA Sec. 1001 /PHSA 2718</p>	<p>Carriers must report to HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums.</p>	<p>FL Insurance Code</p> <p>There is no current statutory authority to implement new MLR requirements or to govern insurer compliance with required notices related to rebate determinations.</p>	<p>MLR Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets.</p>

Rate increase in excess of 10% filed on or after July 1, 2010

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<p>15. Rate Review</p> <p>A rate increase in excess of 10% for increases filed on or after July 1, 2011</p>	<p>All non-grandfathered fully-insured plans</p> <p>PPACA Sec. 1003 /PHSA 2794</p>	<p>Rates subject to review. A rate increase in excess of 10% for increases filed on or after July 1, 2011.</p> <p>If a state reviews the increase, HHS will adopt the state's determination and will post the state's final determination on its website.</p> <p>If the issuer implements an unreasonable increase, it must submit a final justification to HHS and prominently post the information on the company web site for at least 3 years.</p>	<p>FL Insurance Code</p> <ul style="list-style-type: none"> FL has been determined by HHS to have an effective rate review program for individual and small group policies. HHS has determined FL does NOT have an effective rate review program for association policies (rates for out of state associations are not subject to OIR rate approval (s. 627.410(1)); 	<p>FL does NOT approve rates for large group policies with 51 or more persons per s. 627.410(6)(a).</p> <p>In making a determination that a state has an effective rate review system, HHS requires a state to maintain on its website a user-friendly program to permit consumer review of proposed rate changes and to file comments prior to final state action.</p> <p>The OIR has implemented access to rate filings, and continues to make information more complete and more user friendly – although additional resources for technology upgrades would facilitate making additional changes.</p>

Effective January 1, 2012

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes	
<p>16. Accountable Care Organizations (ACOs)</p>	<p>(Effective January 1, 2012 for Medicare only contracts only)</p>	<p>ACOs are authorized to participate as health plans offering coverage through an Insurance Exchange.</p>	<p>FL Insurance Code</p> <p>Currently, there are no FL insurance solvency or benefit laws that would apply to this new risk-bearing entity.</p>	<p>ACOs are authorized for participation in the State's Medicaid Managed Care legislation enacted in 2011.</p>

Effective Within two (2) years – September 23, 2012

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes	
<p>17. Uniform explanation of coverage documents and standardized definitions</p>	<p>All plans PPACA Sec. 1001 /PHSA 2715</p>	<p>The Secretary must develop standards for a summary of benefits and coverage (SBC) explanation to be provided to all potential policyholders and enrollees.</p> <p>The SBC must be made available in a culturally and linguistically appropriate manner.</p> <p>HHS issued its Final Regulation in February 2012 (45 CFR Part 147).</p>	<p>FL Insurance Code</p> <p>At s. 641.31(1) and (4) HMOs are required to provide disclosures including a member handbook.</p> <p>At s. 624.308, 627.642, 627.643 and 69O-154.107 FAC (Individual) there are some standards for outlines of coverage.</p>	<p>FL laws governing disclosures, a summary of benefits and coverage (SBC) and illustrative materials would need to be amended/created to align with the HHS Final Rule.</p>
<p>18. Ensuring quality of care Effective: 2 years after enactment</p>	<p>All non-grandfathered plans PPACA Sec. 1001 /PHSA 2717</p>	<p>Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan improve health outcomes.</p>	<p>FL Insurance Code</p> <p>Current annual reporting requirements for health and accident insurance are at s. 627.9175.</p>	<p>Current FL law does not require regulated health plans to provide a report on health outcomes,</p>

Effective in 2013

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<p>19. Administrative simplification requirements</p> <p>Rules adopted by July 1, 2011 to become effective by January 1, 2013.</p>	<p>PPACA Sec. 1104 /SSA 1171</p>	<p>The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information</p> <p>HHS Interim Final Rule issued January 10, 2012.</p>	<p>FL Insurance Code</p> <p>At s. 627.611, s. 627.647, s. 627.6132 – FL law governs claim forms.</p> <p>At s.627.6132 -- payment of claims, the law requires use of specific Health Care Financing Administration (HCFA) claim form (or its successor form).</p>	<p>It is unknown if requirements regarding the standards of claims information and/or standardized billing requirements would require amendments to the Florida Insurance Code.</p>
<p>20. Co-Op Plans – Consumer Owned and Operated (Health Plans)</p>	<p>PPACA Sec. 1322</p>	<p>UPDATE: 01/2013:</p> <p>HHS has discontinued the Co-Op funding program. No Co-Op proposals were received by the FL OIR.</p>	<p>FL Insurance Code</p>	<p>As outlined in PPACA , a Co-Op entity in this State, as a risk-bearing entity, would be regulated by the OIR – and preliminary review suggested a Co-Op would be determined to be a form “mutual insurance company” for purposes of solvency regulation.</p>

Effective Plan Year January 1, 2014

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
<p>21. Pre-existing condition exclusions</p>	<p>All plans except grandfathered individual market plans</p> <p>PPACA Sec. 1201 /PHSA 2704</p>	<p>A plan may not impose any pre-existing condition exclusions.</p>	<p>FL Insurance Code There are a number of FL statutes (and rules) related to coverage of pre-existing conditions:</p> <p>627.6045; 627.6561; and 641.3107 -- Preexisting condition; Related statutes: 627.64871; 641.31 (16) Health Maintenance contracts;641.185(h);</p>	<p>FL law currently permits waiting periods before pre-existing conditions are covered. Federal law would appear to prevent the imposition of such waiting periods.</p> <p>Rules (partial list) adopted pursuant to current statutes governing pre-existing condition coverage requirements:</p> <p>69O-154.105(5) Standards for Policy Provisions- Pre-existing conditions; 69O-154.110. Certificate of Creditable Coverage.; 69O-154.111. Demonstration of Creditable Coverage</p>
<p>22. Fair health insurance premiums</p>	<p>Non-grandfathered fully-insured small group and individual plans.</p> <p>Fully insured large group plans in states that allow them to purchase through the Exchange.</p> <p>/PHSA 2701</p>	<p>Premiums may only vary by:</p> <ul style="list-style-type: none"> • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family <p>November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans.</p>	<p>FL Insurance Code</p> <p>s. 627.411 --- Grounds for policy form and rate disapproval ...</p> <p>At (f)(1) a health insurance policy form (and rate) may be disapproved if the policy ... “Provides benefits that are unreasonable in relation to the premium charged”</p>	<p>The statutory standard – that the policy provides benefits that are [not] unreasonable in relation to premium charge – is supported by a set of OIR rules governing rate filings. Certain of these rules now conflict with the PPACA requirement that rate factors may <u>only</u> be developed using the four factors – age, tobacco, geographic rating area, and individual vs. family composition.</p> <p>In addition, under PPACA, rates may not vary by gender – a change from current FL regulatory standard that permits gender rating.</p> <p>Principal FL rules containing references to rate filing requirements are 69O-149.0025; 149.003; 149.005; 149.006; 149.007</p>

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<p>23. Guaranteed availability of coverage</p>	<p>Non-grandfathered fully-insured plans. /PHSA 2702</p>	<p>Insurers must accept every employer and every individual that applies for coverage except : an insurer may restrict enrollment based upon open or special enrollment periods. November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans</p>	<p>FL Insurance Code At s. 627.6699(5), current FL law requires guarantee issue products in the small group market (including groups of one).</p>	<p>FL does not require guarantee issue in the individual market unless the individual is Health Insurance Portability and Accountability Act (HIPAA) eligible – i.e., has exhausted the 18 month policy term of a Consolidated Ominbus Budget Reconciliation Act (COBRA) or (state COBRA) policy. See s.627.6425 Renewability of individual coverage</p>
<p>24. Guaranteed renewability of coverage</p>	<p>All non-grandfathered fully-insured plans. /PHSA 2703</p>	<p>Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual. November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans</p>	<p>FL Insurance Code FL Insurance Code currently provides for guarantee renewable health insurance policies and HMO contracts.</p> <ul style="list-style-type: none"> • See Statutes: s.627.6425 Individual; s. 627.6571 Group; s.641.31074 Group HMOs 	

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<p>25. Prohibiting discrimination against individual participants and beneficiaries based on health status</p>	<p>All non-grandfathered plans /PHSA 2705</p>	<p>A plan may not establish rules for eligibility based on any of the following health status-related factors: Health status; Medical condition; Claims experience; Receipt of health care; Medical history; Generic information; Evidence of insurability (including conditions arising out of domestic violence); Disability; Any other health-status related factor deemed appropriate by the Secretary</p>	<p>FL Insurance Code Current FL law prohibits <u>unfair</u> discrimination – see s. 626.9541 (1)(g)3.</p>	<p>November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans Florida law and rules would need to be amended to align with HHS Rule.</p>
<p>26. Non-discrimination in health care</p>	<p>All non-grandfathered plans /PHSA 2706</p>	<p>Plans may not discriminate against any provider operating within their scope of practice. Does NOT require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon whether they receive subsidies, provide information to state or federal investigators, etc.</p>	<p>FL Insurance Code At s. 627.419 and s. 641.19(12) and related statutes, FL law provides for provider participation based on scope of license related to benefits provided in the health plan.</p>	<p>The FL Insurance Code does not currently contain anti-discrimination provisions related to receipt of subsidies (available only through an exchange) or whether a person has provided information to a federal investigator</p>
<p>27. Prohibition on Excessive Waiting Periods</p>	<p>All group plans /PHSA 2708</p>	<p>Group health plans and group health insurance may not impose waiting periods that exceed 90 days.</p>	<p>FL Insurance Code At s. 627.6561(1)(c) waiting period is defined, but does not specify a time period restriction.</p>	<p>Current statutes do not contain waiting period restrictions applicable to group insurance policies</p>

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<p>28. Wellness Programs</p>	<p>Non-grandfathered individual market plans /PHSA 2705</p>	<p>Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health status-related factor <i>must limit such rewards to 30% of the cost of coverage</i>. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. <i>Existing wellness programs established before March 23, 2010, may continue to be carried out.</i></p>	<p>FL Insurance Code At s.627.6402, FL authorizes insurance rebates for healthy lifestyles <i>and places a 10% cap of paid premium</i>. At s. 626.9541(4) – under the Unfair Trade Practice Act – there are additional standards for wellness incentive program participation.</p>	
<p>29. Coverage for individuals participating in approved clinical trials</p>	<p>All non-grandfathered plans /PHSA 2709</p>	<p>A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.</p>	<p>FL Insurance Code Does not currently contain provisions governing participation in clinical trials.</p>	
<p>30. Rating reforms must apply uniformly</p>	<p>PPACA Sec. 1252</p>	<p>Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.</p>	<p>FL Insurance Code There are no FL statutes that would require uniform application of standards or requirements of Title I of PPACA legislation.</p>	

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
<p>31. (Essential Health Benefits) Comprehensive health insurance coverage</p>	<p>All non-grandfathered plans /PHSA 2707</p>	<p>All plans must include the essential benefits package required of plans sold in the Exchanges.</p> <p>All plans must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).)</p> <p>If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.</p>	<p>FL Insurance Code</p> <p>At s. 641.19(4) there is a definition of “comprehensive medical services” for purposes of defining a “comprehensive” medical services HMO contract.</p> <p>There is no corresponding definition in Ch. 627 to define a “comprehensive” or “major medical” health insurance (indemnity) policy.</p> <p>At OIR Rule O69-154.106(5) there are a set of requirements governing the review/approval of a “major medical” plan.</p>	<p>HHS has published a series of guidance documents related to essential health benefits.</p> <p>The set of essential health benefits will vary from state to state depending on that state’s choice or (by default) HHS determination.</p>
<p>32. Insurance Exchanges</p>	<p>PPACA Sections 1301-1321</p>	<p>States or Federal Government required to establish Insurance Exchanges in every state – to become operational for plan years beginning January 1, 2014.</p>	<p>FL Insurance Code</p> <p>Florida Insurance Code would need amendment to clarify the OIR’s regulatory role for contracts and rates associated with a Federally Facilitated or Federal Partnership Exchange model.</p>	
<p>33. Level Playing Field/Multi-State Plans</p>	<p>PPACA Sec. 1324</p>	<p>Health insurance plans shall not be subject to a set of requirements unless Co-Op plans and multi-state plans are also subject to them.</p>	<p>FL Insurance Code</p> <p>There are no current statutory standards for review of a multi-state plan.</p>	<p>The Federal Office of Personnel Management (OPM) HHS published a proposed Rule, 45 CFR Part 800 on November 30, 2012 to establish the Multi-State Plan Program for Insurance Exchanges.</p>

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
<p>34. Transitional reinsurance program for individual market in each state</p>	<p>Effective: Plan years beginning in 2014 through 2016 PPACA Sec. 1341</p>	<p>All plans must pay assessments. Non-grandfathered individual plans may receive payments.</p> <p>States shall enact a model regulation established by the Secretary, in consultation with the NAIC that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016.</p>	<p>FL Insurance Code</p> <p>If a state does not elect to establish a reinsurance program, the program will be administered by the HHS.</p>	<p>The reinsurance standards applicable to this program will govern the re-integration of the PCIP population back into the regulated health plan market – inside and outside an exchange program</p> <p>HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012.</p>
<p>35. Risk adjustment</p>	<p>Non-grandfathered individual and small group plans PPACA Sec. 1343</p>	<p>Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees have an actuarial risk that is greater than the average arial risk in that state.</p>	<p>FL Insurance Code</p> <p>There is no statutory authority for the OIR to administer a risk adjustment program for issuers with a Certificate of Authority (COA) in FL.</p>	<p>The risk adjustment program will be applicable to the regulated health plan market – inside and outside an exchange program.</p> <p>HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012</p>
<p>36. Establishment of risk corridors for plans in individual and small group markets</p>	<p>Qualified health plans; Non-grandfathered individual and small group plans PPACA Sec. 1342 1343</p>	<p>Effective: for Calendar years 2014-2016 Plans will receive payments if the ratio of non-administrative costs, less risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.</p>	<p>FL Insurance Code</p> <p>To be administered by HHS for products offered through Insurance Exchanges.</p>	<p>HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012</p>