FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Friday, December 15, 2023, 9:00 AM
Conference Call
Call-In Number: 866-299-7949
Code: 1433866#

AGENDA

I. **Call to Order**

II. **Roll Call - Attachment**

III. **Antitrust Statement - Attachment**

IV. **Approval of Minutes, November 17, 2023 - Attachment**

V. **State of the Market Annual Report Approval - Attachment**

VI. **Executive Director's Report – Attachments**

VII. **Discussion/Approval of Legislative Proposals for 2024 – Attachment**

VIII. **Other Business**

IX. **Public Comment**

X. **Adjourn**

Table of Contents

Attachment A

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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Employers or Employer Representatives

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Term Ending: 12/31/2023
Carrier

Vacant
Agent

Vacant
Agent

As of December 12, 2023

Attachment B

FLORIDA HEALTH INSURANCE ADVISORY BOARD

BOARD MEETING

December 2023

Antitrust Statement

We are here to discuss and act on matters relating to the business of the Florida Health Insurance Advisory Board. We are not here to discuss or pursue the business interests of any individual companies. All of us should proceed with caution and awareness of the requirements and prohibitions of federal and state antitrust laws. We should not engage in discussions, either at this meeting or in private conversation, of our individual companies' plans or contemplated activities. We should concern ourselves only with the business of the Florida Health Insurance Advisory Board, as set forth in the agenda for this meeting and each company's business plans cannot be discussed. If you have questions, please contact the General Counsel.

Attachment C

DRAFT

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Friday, November 17, 2023, 9:00 AM
Via Teleconference
Tallahassee, FL

Board Members Present:

Alexis Bakofsky, Chair	Louisa McQueeney	Eric Johnson
Christina Lake	Robert Muszynski	Bill Herrle
Rick Wallace	Seth M. Phelps	Richard Weiss

Others Present:

- Jack McDermott, FHIAB Executive Director
- Shannon Doheny, Assistant General Counsel, Office of Insurance Regulation (OIR)

I. Call to Order

Alexis Bakofsky (Chief of Staff, Office of Insurance Regulation), as the Chair, called the meeting to order at 9:00 am, indicating the meeting was properly noticed to the public in accordance with Florida Law. The Chair thanked the members for their attendance.

II. Roll Call

Jack McDermott conducted a roll call of members. A quorum was present.

III. Antitrust Statement

Shannon Doheny was recognized to review the antitrust statement.

IV. Approval of Minutes, September 28, 2023

The Chair presented the minutes from the Board's September 28, 2023, meeting and asked for questions or comments. The Chair accepted a motion from Richard Weiss to approve the minutes, seconded by Seth Phelps. The minutes were approved without changes.

V. Executive Director's Report

The Chair recognized Jack McDermott to present the executive director's report. Mr. McDermott presented the latest financial statements from October 31, 2023, and noted the Board has roughly $70,000 in net assets, which is enough to sustain the Board until the next round of assessments. He also noted that Purvis Gray is in the process of conducting the 2022 financial audit, and that a draft procedures manual (with updated procedures to address findings in prior audits) has been shared with the auditor and will potentially be included as a subsequent event.

The Chair asked if any Board members had questions. Hearing none, the Chair moved to the next agenda item.

VI. Legislative Proposals for 2024

The Chair moved to the next agenda item, noting the purpose of the meeting today is to hear legislative proposals submitted by Board members and discuss them; a Board vote on these proposals will occur during a future meeting.

All eight (8) of the proposals were submitted by Louisa McQueeney, so she presented them:

- Proposal # 1: Deductible Health Credit Transfer
- Proposal # 2: Provide Health Care Consumers with One Free Copy of their Own Medical Records
- Proposal # 3: Protect Consumers from Prescription Drug Formulary Changes During a Policy Year
- Proposal # 4: Cap the Cost of Insulin at $35 a Month
- Proposal # 5: Prohibit Balance Billing for Ground Emergency Medical Transportation
- Proposal # 6: Include Applied Behavioral Analysis as a Covered Benefit in all Insurance Plans
- Proposal # 7: Add Fetal Alcohol Spectrum Disorder (FASD) to Include to the Definition of the Term Developmental Disabilities
- Proposal # 8: Apply Payments by, or on Behalf of, a Beneficiary to Count Toward the Out-of-Pocket Cost Sharing Calculations

The Chair asked the Board if there were any questions. As these were similar to proposals submitted (and approved) in prior years, there were no questions or comments at this meeting. The Chair noted that if any Board member has a question or suggestion for change, they should contact the Executive Director Jack McDermott prior to the next Board meeting.

VII. Other Business

The Chair asked if any Board member had other business to bring before the Board. Louisa McQueeney noted the Board meetings were happening later in the year, suggesting they could be done earlier.

VIII. Public Comment

The Chair asked if anyone from the public had comments about any of the items discussed during the Board meeting. Two members of the public requested time to speak, and both expressed support for Legislative Proposal # 8 -- Apply Payments by, or on Behalf of, a Beneficiary to Count Toward the Out-of-Pocket Cost Sharing Calculations:

1. Doreen Glenn (mother of son with expensive medication)
2. Donna Sabatino, RN (State Policy & Advocacy Director, AIDS Institute)

IX. Adjourn

The Chair thanked everyone who participated and provided public comment. Having completed the agenda, the Chair adjourned the meeting.

_____ _____

Prepared by: Jack McDermott, Executive Director Approved by Board

Attachment D

2023 FLORIDA HEALTH INSURANCE MARKET REPORT

BY THE

FLORIDA HEALTH INSURANCE ADVISORY BOARD

Adopted December ***, 2023

Introduction

One of the responsibilities of the Florida Health Insurance Advisory Board (FHIAB) is to issue an annual report on the state of the health insurance market in Florida.

The following figures present enrollment, premium, and loss ratio summaries in Florida's commercial (non-governmental) major medical health insurance markets as reported and compiled from data filed with the Office of Insurance Regulation (Office) by each Accident and/or Health Coverage provider. This report incorporates insurance company data submitted to the Office for the year ending December 31, 2022. Previous reports are available on the FHIAB section of the Office's website at: https://floir.com/life-health/florida-health-insurance-advisory-board.

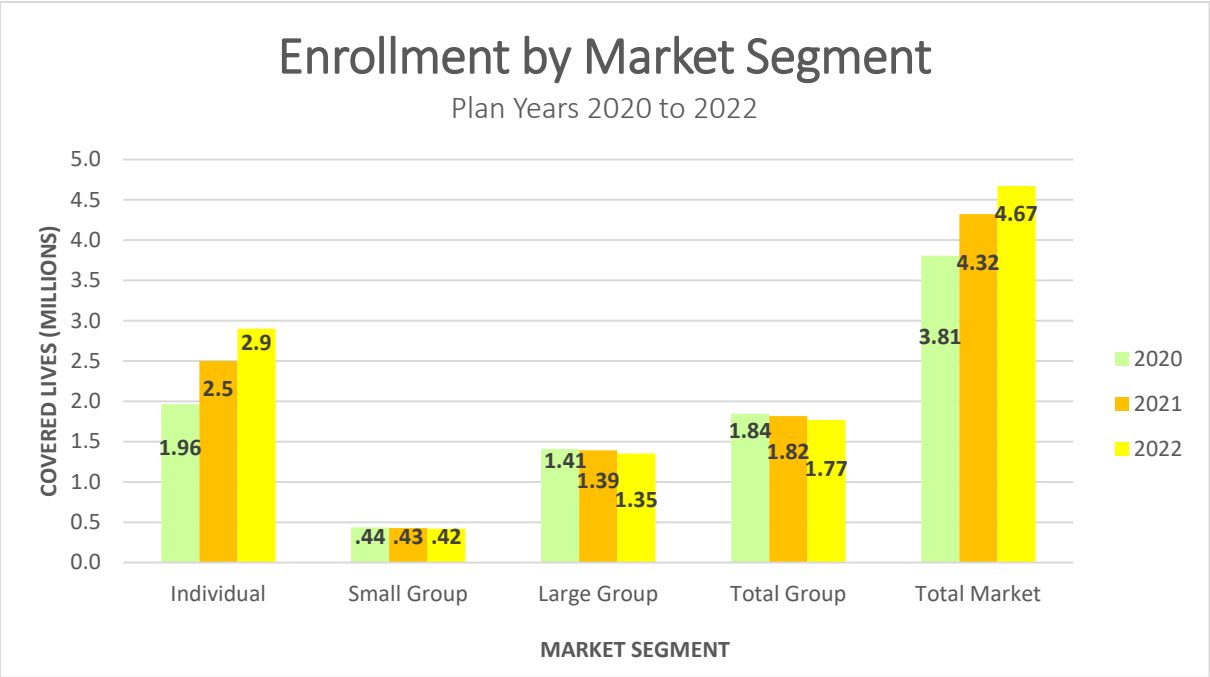
Executive Summary

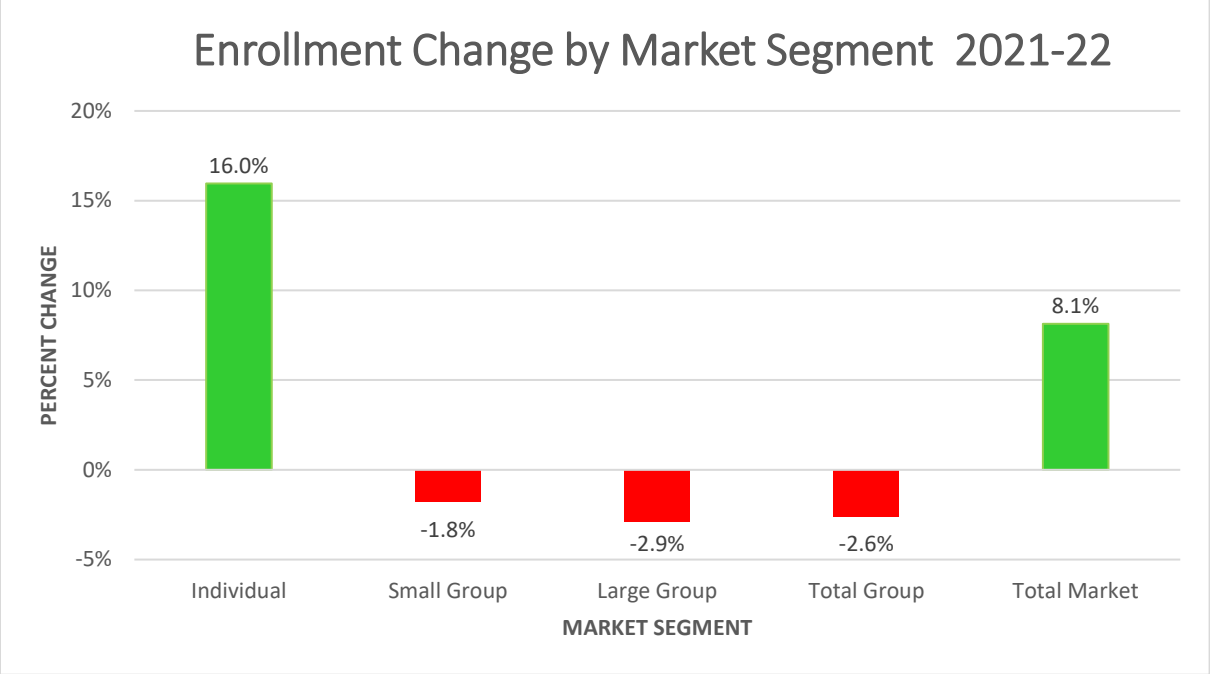
Overall enrollment continued to grow, with gains in the individual market offsetting minor losses in the group markets (both small group and large group). Rates have largely stabilized leading to smaller changes, and the long-term trend of increasing individual enrollment and decreasing group enrollment is not only consistent – the gap continues to widen.

Today, in the State of Florida, people covered under individual policies exceed those covered under a group policy. Under the Affordable Care Act (ACA), all individual policies must be guaranteed issue; no application can be rejected based on the health status of the applicant. The individually underwritten policies reported herein are either grandfathered policies, which means they were issued before the passage of the ACA and can be renewed indefinitely, or transitional policies, which means they were issued after passage of the ACA. Transitional policies were extended indefinitely on March 23, 2022, by a bulletin issued by the Centers for Medicare & Medicaid Services (CMS). Regardless, many individual policyholders have already moved to an ACA-compliant policy due to the subsidies available on the Federal Marketplace, reducing the market share of grandfathered and transitional policies.

Both the small group and large group markets continue to contract, and this trend is not expected to change. The percentage decline from 2021 to 2022 increased slightly relative to prior years and may have been related to lingering effects of COVID-19 as well as a restructuring of the workforce. In addition, carriers have been active in developing products that help employers reduce costs by self-insuring, which is a continuing trend.

Commercial Enrollment





As illustrated above and shown in Table 1 below, total enrollment in Florida's commercial health insurance markets increased in 2022 by 351,541 covered lives or 8.1%. This follows an increase from the previous year of 512,565 covered lives or 13.5%. The overall market remains significantly larger than before the ACA, and the large increase noted in the 2021 data is not an anomaly as the increase continued (although slightly moderated) in 2022.

As of year-end 2022, coverage by market segment consisted of:

- **Individual Coverage –** 2,900,344, an increase of 399,110 covered lives or 16.0%
- **Small Group** (1-50 members) **–** 420,276, a decrease of 7,630 covered lives or 1.8%
- **Large Group** (51+ members) **–** 1,351,060, a decrease of 39,939 covered lives or 2.9%
- **Total Market –** 4,671,680 an increase of 351,541 covered lives or 8.1%

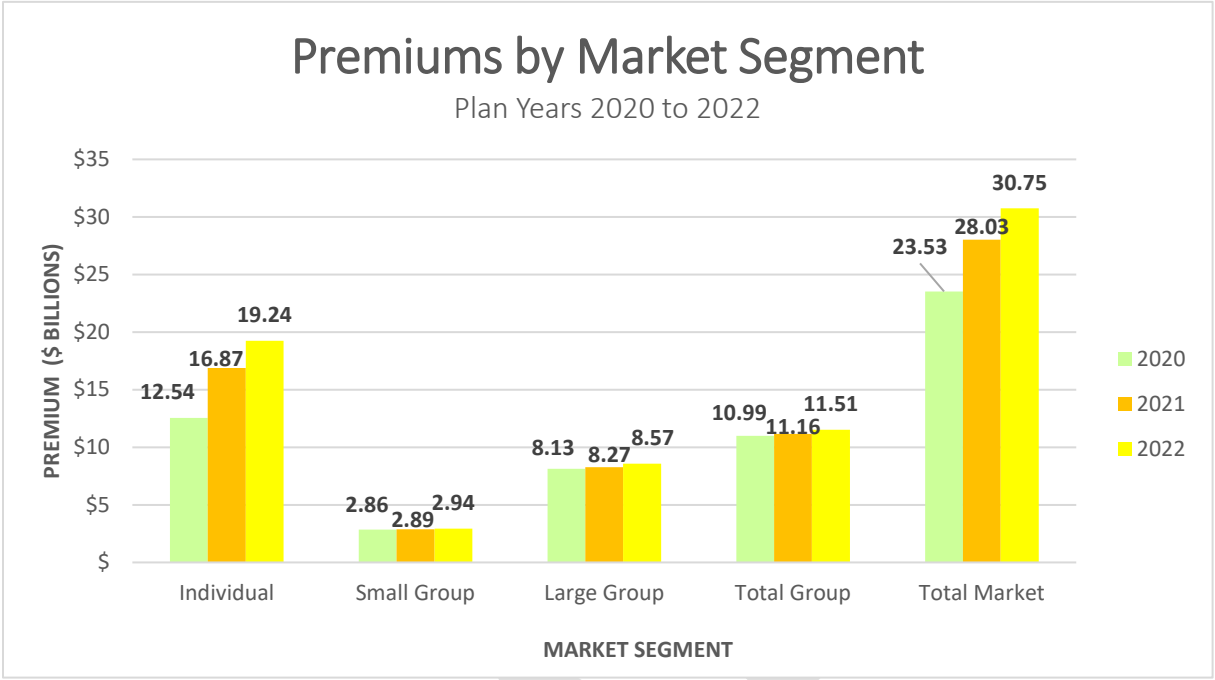
The individual market enrollment continues to grow despite the implied tax penalty (individual mandate) being set to $0 and changes to federal and state law that encourage growth of alternative products such as short-term limited duration policies (up to 364 days) and health care sharing ministries. In general, the individual market remains attractive for those with income levels that qualify for subsidies on the Marketplace but less attractive for those who do not qualify for subsidies. In 2021, the individual market overtook the group market in terms of enrollment – which accelerated dramatically in 2021 as the individual market grew 27.4%, while the small group market declined 1.9% creating an even larger gap. This trend continued in 2022 with the individual market growing 16.0%, while the small group market declined 1.8%.

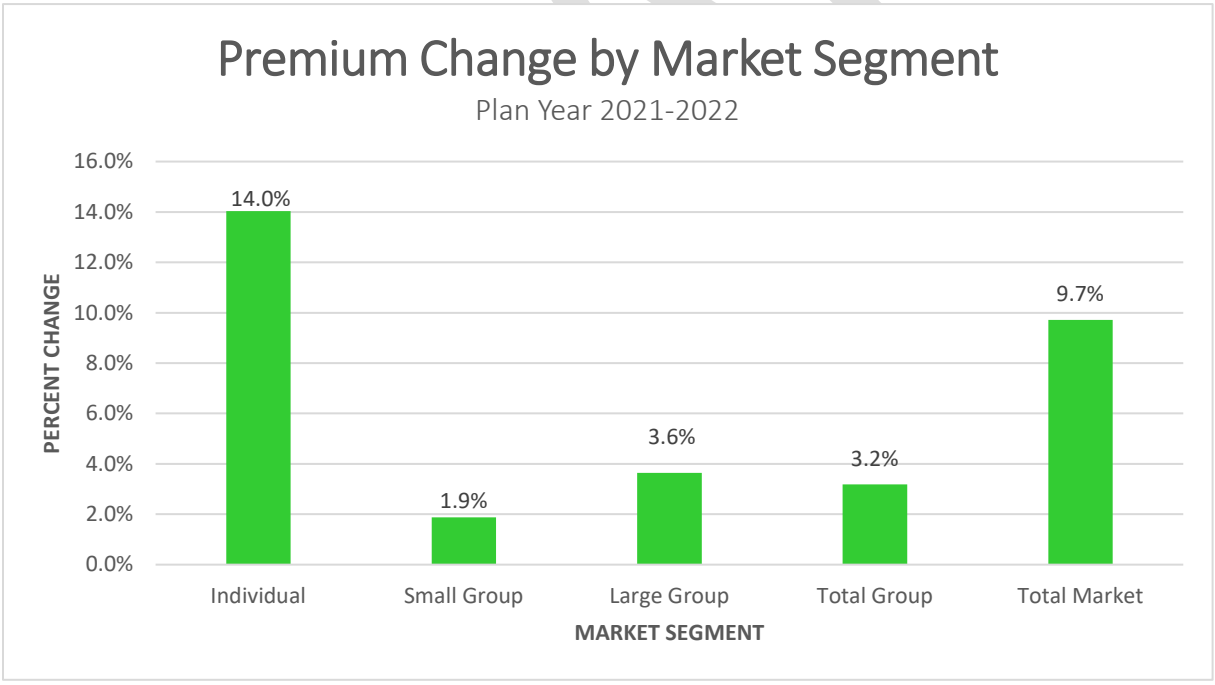
In contrast to the individual market, enrollment in the total group market continues to decline. The declining trend in group coverage was in effect prior to the implementation of the ACA as small group enrollment was 1,073,683 in 2005 but had dropped to 598,361 in 2014 and large group enrollment declined from 2,468,056 in 2005 to 1,628,198 in 2014. The declining trends in group enrollment have generally slowed down (but continued) possibly due to COVID-19 and its effects on employment. Other contributing factors may be that carriers have been active in developing products that help employers reduce costs by self-insuring. In addition, some small employers have chosen to stop offering coverage for their employees and their dependents as their employees can often pay less by purchasing a policy through the Federal Marketplace if those employees qualify for a subsidy.

Table 1
Commercial Insurance Enrollment 2020-2022

Market Segments	2020	2021	2022
Individual Guaranteed Issue			
ACA On-Exchange	1,676,923	2,199,609	2,630,125
ACA Off-Exchange	145,030	200,346	185,310
Grandfathered (In-State and Out-of-State)	301	284	246
Transitional (In-State and Out-of-State)	26	25	20
Total Guaranteed Issue	1,822,286	2,400,264	2,815,701
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	36,473	32,356	27,334
Transitional (In-State and Out-of-State)	103,789	68,444	57,203
Total Individually Underwritten	140,262	100,800	84,537
Conversion			
Total Conversion	138	170	106
Small Groups (1-50)			
Self-Employed or Sole Proprietor	100	80	57
2 – 50 Member Groups	436,141	427,826	420,219
Total Small Groups	436,241	427,906	420,276
Large Groups (51+)			
Total Large Groups	1,408,647	1,390,999	1,351,060
Market Totals			
Total Individual Market	1,962,686	2,501,234	2,900,344
Total Group Market	1,844,888	1,818,905	1,771,336
Total Commercial Market	3,807,574	4,320,139	4,671,680

Commercial Premium



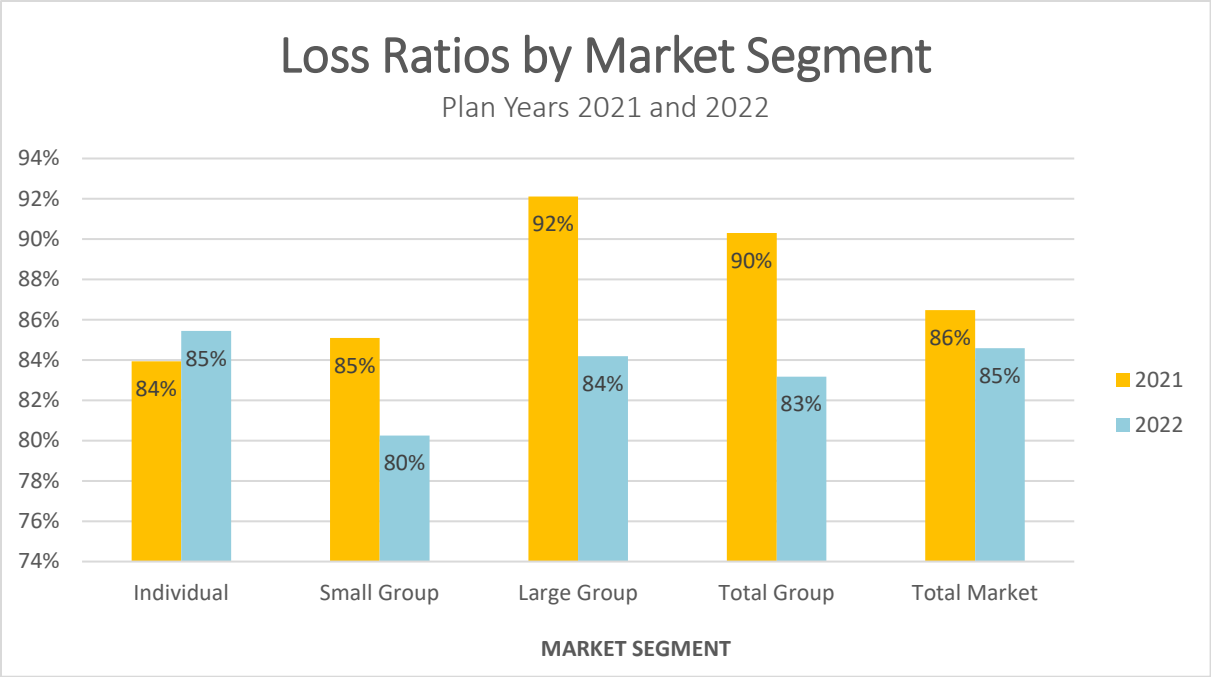


As illustrated above and shown in Table 2 below, the overall commercial market generated $30,750,297,716 in premiums in 2022, 9.7% increase from 2021. This follows a 19.1% increase the prior year. The increase is largely the result of the higher enrollment in the individual market and higher premiums per member in all markets.

Table 2
Commercial Insurance Premium 2020-2022

Market Segments	2020	2021	2022
Individual Guaranteed Issue			
Grandfathered (In-State and Out-of-State)	$808,697	$611,513	$451,948
Transitional (In-State and Out-of-State)	$476,295	$348,047	$331,912
ACA On-Exchange	$10,698,864,079	$15,093,892,765	$17,534,106,462
ACA Off-Exchange	$1,114,074,761	$1,223,834,541	$1,162,947,165
Total Guaranteed Issue	$11,819,087,384	$16,318,686,866	$18,703,174,317
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	$231,442,132	$203,547,896	$196,782,090
Transitional (In-State and Out-of-State)	$487,977,024	$349,056,939	$337,867,456
Total Individually Underwritten	$719,419,156	$552,604,835	$534,649,546
Conversion			
Total Conversion	$932,725	$637,218	$1,095,243
Small Groups (1 – 50)			
Self-Employed or Sole Proprietor	$873,161	$699,306	$577,277
2 – 50 Member Groups	$2,855,835,726	$2,889,626,140	$2,944,225,548
Total Small Groups	$2,856,708,887	$2,890,325,446	$2,944,802,825
Large Groups (51+)			
Total Large Groups	$8,134,888,794	$8,265,413,042	$8,566,575,785
Market Totals			
Total Individual Market	$12,539,439,266	$16,871,928,920	$19,238,919,106
Total Group Market	$10,991,597,681	$11,155,738,488	$11,511,378,610
Total Commercial Market	$23,531,036,547	$28,027,667,408	$30,750,297,716

Loss Ratios



The loss ratios provided above are calculated by dividing the losses associated with various market segments by the amount of premiums collected. As expected, each market demonstrates a different loss ratio profile.

The loss ratios decreased "across-the-board" in all categories except for the individual market which had a very modest increase.

In the individual market, the overall loss ratio increased from 83.93% in 2021 to 85.44% in 2022 while the small group overall loss ratio decreased from 85.09% in 2021 to 80.26% in 2022.

The large group market experienced an overall loss ratio decrease from 92.12% in 2021 to 84.19% in 2022. This market segment has a higher volume and lower administrative cost environment; consequently, higher loss ratios are generally expected in this market segment relative to other markets.

Table 3
Direct Premium/Losses & Loss Ratios 2021-2022

Market Segments	2021			2022		
Individual Guaranteed Issue	Direct Premium Earned	Direct Losses Incurred	Loss Ratio	Direct Premium Earned	Direct Losses Incurred	Loss Ratio
Grandfathered (In-State and Out-of-State)	$611,513	$979,754	160.22%	$451,948	$680,738	150.62%
Transitional (In-State and Out-of-State)	$348,047	$313,100	89.96%	$331,912	$353,238	106.43%
ACA On-Exchange	$15,093,892,765	$12,719,380,598	84.27%	$17,534,106,462	$15,066,004,579	85.92%
ACA Off-Exchange	$1,223,834,541	$945,637,323	77.27%	$1,162,947,165	$904,087,317	77.74%
Total Guaranteed Issue	$16,318,686,866	$13,666,319,775	83.75%	$18,703,174,317	$15,975,837,175	85.42%
Individually Underwritten						
Grandfathered (In-State and Out-of-State)	$203,547,896	$164,396,999	80.77%	$196,782,090	$150,978,359	76.72%
Transitional (In-State and Out-of-State)	$349,056,939	$327,335,487	93.78%	$337,867,456	$306,123,234	90.60%
Total Individually Underwritten	$552,604,835	$491,732,486	88.98%	$534,649,546	$457,101,593	85.50%
Conversion						
Total Conversion	$637,218	$2,857,136	448.38%	$1,095,243	$4,586,808	418.79%
Small Groups (1 – 50)						
Self-Employed or Sole Proprietor	$699,306	$1,337,535	191.27%	$577,277	$1,119,410	193.91%
2 – 50 Member Groups	$2,889,626,140	$2,458,037,765	85.06%	$2,944,225,548	$2,362,419,233	80.24%
Total Small Groups	$2,890,325,446	$2,459,415,300	85.09%	$2,944,802,825	$2,363,538,643	80.26%
Large Groups (51+)						
Total Large Groups	$8,265,413,042	$7,614,456,891	92.12%	$8,566,575,785	$7,212,113,718	84.19%
Market Totals						
Total Individual Market	$16,871,928,920	$14,160,900,397	83.93%	$19,238,919,106	$16,437,525,576	85.44%
Total Group Market	$11,155,738,488	$10,073,872,191	90.30%	$11,511,378,610	$9,575,652,361	83.18%
Total Commercial Market	$28,027,667,408	$24,234,772,588	86.47%	$30,750,297,716	$26,013,177,937	84.59%

Background

The FHIAB evolved from small group health insurance reform in Florida. Originally established in 1992 as the Florida Small Employer Health Reinsurance Program, it was expanded in 1997 to include the Florida Individual Health Reinsurance Program. Both Programs were governed by the same Board of Directors and operated as the Florida Health Reinsurance Program.

Florida law changes in 2005 directed the Program to advise the Office of Insurance Regulation, the Agency for Health Care Administration, the Department of Financial Services, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.
2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.
3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.
4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.
5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

In light of these developments, the Board voted to change its name to the Florida Health Insurance Advisory Board, which better reflected its new responsibilities.

The composition of the board of directors was also changed to decrease the number of insurance company representatives and to add representatives of the business community and other stakeholders. There are 14 members of the Board as prescribed by statute. A current listing of the FHIAB directors as of December 2023 follows:

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD OF DIRECTORS

Alexis Bakofsky, Chair Designee
Chief of Staff
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Stefan Grow
Chief of Staff
Florida Agency for Health Care Admin.
2727 Mahan Drive, Mailstop #2
Tallahassee, FL 32308

Louisa McQueeney
Communications Director
Florida Voices for Health
9653 El Clair Ranch Road
Boynton Beach, FL 33437
Term Ending: 12/31/2023

Christina Lake
Executive Vice President
Datamaxx Group, Inc.
2001 Drayton Drive
Tallahassee, FL 32311
Term Ending: 12/31/2023

William "Bill" Herrle
Executive Director
NFIB
110 East Jefferson Street
Tallahassee, FL 32301
Term Ending: 12/31/2026

Eric Johnson, Ph.D., ASA
Chief Actuary & VP of Analytics
& Business Intelligence
AvMed Health Plans
4300 NW 89th Blvd.
Gainesville, FL 32606
Term Ending: 12/31/2026

Richard B. Weiss, CPA
President, Florida Market
Aetna
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Plantation, FL 33324
Term Ending: 12/31/2024

John J. Matthews
Vice President of Legal, Regulatory and
Government Affairs
Oscar Health
4560 Grove Park Drive
Tallahassee, FL 32311
Term Ending: 12/31/2026

Seth M. Phelps
Assistant General Counsel
Blue Cross and Blue Shield of Florida, Inc.
4800 Deerwood Campus Parkway
DCC1-7th Floor
Jacksonville, FL 32246
Term Ending: 12/31/2026

Rick Wallace
President/CEO
FAMOS, LLC
d/b/a American Academy of Cosmetology
1330 Blanding Blvd, Suite 125
Orange Park, FL 32065
Term Ending: 12/31/2024

Robert Muszynski
Director of Finance and Administration
WMFE (NPR) Radio
11510 E. Colonial Drive
Orlando, FL 32817
Term Ending: 12/31/2024

Nathan Landsbaum
President and CEO, Florida
Sunshine Health
1700 N. University Drive
Plantation, FL 33322
Term Ending: 12/31/2023

Two director positions designated for agents are vacant.

Attachment E

OFFICE OF INSURANCE REGULATION

DAVID ALTMAIER
COMMISSIONER

IN THE MATTER OF: Case No.: 198603-16

FLORIDA HEALTH REINSURANCE PROGRAM
_____/

ORDER APPROVING AMENDMENTS TO
PLAN OF OPERATION

THIS CAUSE came on for consideration upon FLORIDA HEALTH REINSURANCE PROGRAM's (hereinafter referred to as "FHRP") submission to the OFFICE OF INSURANCE REGULATION (hereinafter referred to as the "OFFICE") the amendments to its Plan of Operation for review and approval, pursuant to Section 627.6699(11), Florida Statutes. Following a complete review of the entire record, and upon consideration thereof, and being otherwise fully advised in the premises, the OFFICE hereby finds as follows:

1. The OFFICE has jurisdiction over the subject matter and parties to this proceeding.

2. The FHRP has been established in accordance with Section 627.6699(11), Florida Statutes.

3. Pursuant to Section 627.6699(11)(4)(c)(1) and (3), Florida Statutes, the FHRP shall operate in compliance with a Plan of Operation ("hereinafter referred to as "Plan") approved by the OFFICE. This Plan is subject to continuous review by the OFFICE.

4. The amended Plan of the FHRP is attached hereto as Exhibit A.

5. All of the amendments shall be incorporated herein by reference and are not listed specifically in this order.

WHEREFORE, in consideration of the foregoing and being otherwise duly advised in the premises, it is hereby ORDERED that all amendments to the Plan of Operation of the FLORIDA HEALTH REINSURANCE PROGRAM are hereby APPROVED.

DONE and ORDERED this 17 day of October, 2016.

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

NOTICE OF RIGHTS

Pursuant to Sections 120.569 and 120.57, Florida Statutes and Rule Chapter 28-106, Florida Administrative Code (F.A.C.), you have a right to request a proceeding to contest this action by the Office of Insurance Regulation (hereinafter the "Office"). You may request a proceeding by filing a Petition. Your Petition for a proceeding must be in writing and must be filed with the General Counsel acting as the Agency Clerk, Office of Insurance Regulation. If served by U.S. Mail the Petition should be addressed to the Florida Office of Insurance Regulation at 647 Larson Building, Tallahassee, Florida 32399-4206. If Express Mail or hand-delivery is utilized, the Petition should be delivered to 647 Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300. The written Petition must be received by, and filed in the Office no later than 5:00 p.m. on the twenty-first (21) day after your receipt of this notice. Unless your Petition challenging this action is received by the Office within twenty-one (21) days from the date of the receipt of this notice, the right to a proceeding shall be deemed waived. Mailing the response on the twenty-first day will not preserve your right to a hearing.

If a proceeding is requested and there is no dispute of material fact the provisions of Section 120.57(2), Florida Statutes would apply. In this regard you may submit oral or written evidence in opposition to the action taken by this agency or a written statement challenging the grounds upon which the agency has relied. While a hearing is normally not required in the absence of a dispute of fact, if you feel that a hearing is necessary one will be conducted in Tallahassee, Florida or by telephonic conference call upon your request.

If you dispute material facts which are the basis for this agency's action you may request a formal adversarial proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes. If you request this type of proceeding, the request must comply with all of the requirements of Rule Chapter 28-106.201, F.A.C., must demonstrate that your substantial interests have been affected by this agency's action, and contain:

a) A statement of all disputed issues of material fact. If there are none, the petition must so indicate;

b) A concise statement of the ultimate facts alleged, including the specific facts the petitioner contends warrant reversal or modification of the agency's proposed action;

c) A statement of the specific rules or statutes the petitioner contends require reversal or modification of the agency's proposed action; and

d) A statement of the relief sought by the petitioner, stating precisely the action petitioner wishes the agency to take with respect to the agency's proposed action.

These proceedings are held before a State hearing officer of the Division of Administrative Hearings. Unless the majority of witnesses are located elsewhere the Office will request that the hearing be conducted in Tallahassee.

In some instances you may have additional statutory rights than the ones described herein.

Failure to follow the procedure outlined with regard to your response to this notice may result in the request being denied. Any request for administrative proceeding received prior to the date of this notice shall be deemed abandoned unless timely renewed in compliance with the guidelines as set out above.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of this Order was sent by Certified Mail, Return Receipt Requested and via E-Mail to the following:

Carol A. Ostapchuk, Executive Director
Florida Health Insurance Advisory Board
5151 Wild Rose Way
Tallahassee, FL 32312
E-Mail: ostapchukc@aol.com

on this 19 day of October, 2016.

Jennifer A. Milam
Assistant General Counsel
Florida Bar: 89831
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399
Telephone: (850) 413-4281
Facsimile: (850) 922-2543
E-Mail: jennifer.milam@floir.com

Florida Health Reinsurance Program

Operating as

The Florida Health Insurance Advisory Board

PLAN OF OPERATION

EXHIBIT A

Updated: July 2016

Table of Contents

FLORIDA HEALTH REINSURANCE PROGRAM
PLAN OF OPERATION ("PLAN")

Article I – Purpose

The Florida Health Reinsurance Program (the Program) is a nonprofit entity created pursuant to the Employee Health Care Access Act (Section 627.6699, F.S. as amended), referred to in this Plan as the Small Employer Act. The Program's responsibilities were supplemented by the adoption of Section 627.6475, F.S., referred to in this Plan as the Individual Act. Together, the Small Employer Act and the Individual Act are referred to in this Plan as the Acts.

The purposes of the Program are:

A. To support the goal of the Small Employer Act, which is to promote the availability of health care coverage to small employers regardless of their claim experience or their employees' health status.

B. To facilitate the provision of a Standard Health Benefit Plan and a Basic Health Benefit Plan to be offered to all Small Employers by providing reinsurance protection to Small Employer Carriers in parallel with their obligations.

C. To improve the overall fairness and efficiency of the small group health market.

D. To support the goal of providing guarantee issue health insurance to individuals who are eligible for issuance of Individual Health Insurance coverage pursuant to Section 627.6486, F.S.

E. To advise the Office, the Agency for Health Care Administration, the Department of Financial Services, other executive departments, and the Legislature on health insurance issues, pursuant to Section 627.6699(11)(n), F.S.

Article II - Definitions

As used in this Plan:

A. **Basic Health Benefit Plan and Standard Health Benefit Plan** means low-cost health care plans developed pursuant to the Acts.

B. **Board** means the Board of Directors of the Program. **Director(s) of the Board** (also referred to as **Director)** means a member of the Board as defined in the Acts.

C. **Carrier** means an entity as defined in Section (3)(d) of the Acts.

D. **Case Management** means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

E. **Commissioner** means the Director of the Office of Insurance Regulation.

F. **Creditable Coverage** means, with respect to an individual, coverage of the individual as described in Section 627.6561(5) and (6), F.S.

G. **Eligible Dependent** for Small Employer Carrier purposes means the spouse or child of an Eligible Employee, subject to applicable terms of the Health Benefit Plan covering that employee. Eligible Dependent may include a former spouse of an Eligible Employee, for whom a Carrier is contractually obligated to continue existing coverage following divorce or legal separation, under COBRA or other similar law or court decree, for the period of that obligation. Eligible Dependent may also include a natural child, a legally adopted child, a child placed for adoption, a child supported by the employee pursuant to a valid court order, a child for whom the employee is the legal guardian, or a stepchild who lives with the employee.

Eligibility of dependents of Eligible Individuals under the Individual Act shall be determined in accordance with Florida Statutes and applicable rules of the Florida Office of Insurance Regulation and subject to the applicable terms of the Health Benefit Plan covering the Eligible Individual.

H. **Eligible Employee** means an employee who works on a full-time basis, with a normal workweek of 25 or more hours, and who has met any applicable waiting period requirements. This includes a sole proprietor, a partner of a partnership, or an independent contractor, provided that the sole proprietor, partner or independent contractor is treated as an employee under a Health Benefit Plan of an Eligible Small Employer. This definition does not include a part-time, temporary or substitute employee.

I. **Eligible Individual** means an individual, as of the date under which the individual seeks coverage pursuant to Section 627.6487, F. S., who has aggregate creditable coverage of 18 or more months, and whose most recent prior creditable coverage was under a group health plan, a governmental plan, or a church plan, or under health insurance coverage offered in connection with any such plan, and

1. who is not eligible for coverage under:

   a. a group health plan, as defined in section 2791, of the public Health Service Act;

   b. a conversion policy under section 627.6675, F. S., or section 641.3921, F. S.

   c. Part A or Part B of Title XVIII of the Social Security Act; or

   d. a state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage;

2. with respect to whom the most recent coverage within the coverage period was not terminated based on a factor described in Section 627.6571(2)(a) or (b), F.S., relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

3. who, having been offered the option of continuation coverage under a COBRA continuation provision or under section 627.6692, F.S., elected such coverage; and

4. who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

J. **Eligible Small Employer** means a Small Employer who meets the participation, contribution, and other Small Employer Carrier requirements permitted under the Small Employer Act.

K. **Established Geographic Area** means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for network-based health care services to be available to its insureds, members or subscribers.

L. **Extra Insureds** means employees who are covered under a Small Employer's Health Benefit Plan, but do not meet the requirements defined for coverage as an Eligible Employee. These may include part-time employees or retirees providing occasional service.

M. **Guarantee-Issue Basis** means an insurance policy that must be offered to an employer, employee or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

N. **Health Benefit Plan** means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization subscriber contract. It does not include:

1. Policies or contracts covering only accident, specified disease, individual hospital indemnity, credit, dental, vision, disability income, Medicare Supplement, Medicare Risk, or long term care.

2. Coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical-payment insurance.

3. For Small Employer Health Benefit Plans, coverage under individual policies, except as specified in Section (4)(a) of the Small Employer Act; for Individual Health Benefit Plans, coverage under group insurance policies, except as specified in Section (7)(f) of the Individual Act.

O. **Health Insurance Issuer, and Individual Health Insurance** have the same meaning ascribed in Section 627.6487(2), F.S.

P. **Individual Carrier** means any Carrier that offers Health Benefit Plans to Eligible Individuals pursuant to Section 627.6487, F.S.

Q. **Individual Reinsuring Carrier** means an individual carrier that elects to comply with the requirements of subsection (7) of the Individual Act.

R. **Individual Risk-Assuming Carrier** means an individual carrier that elects to comply with the requirements of subsection (6) of the Individual Act.

S. **Late Enrollee** means an Eligible Employee or Eligible Dependent who enrolls in a group health plan at a time other than during:

1. the first period in which the individual is eligible to enroll under the policy or

2. a Special Enrollment Period.

T. **Multiple Employer Welfare Arrangement** is defined as in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for an arrangement which is fully insured within the meaning of Section 514(b)(6) of said Act, as amended.

U. **Office** means the Florida Office of Insurance Regulation.

V. **Pre-existing Condition Provision** means a policy provision which excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage. When allowed by applicable state and federal law, the specific periods are defined in in Section 627.6561, F.S., for Small Employer insurance policies and in Section 641.31071, F.S., for Small Employer Health Maintenance Organization contracts when the group has two or more Eligible Employees.

For Individual Carriers, any preexisting condition exclusion for Eligible Dependents must comply with Sections 627.6561 and 641.31071, F.S., and be consistent with rules of the Florida Office of Insurance Regulation and federal law.

W. **Rating Period** means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

X. **Small Employer**, pursuant to the Small Employer Act, means in connection with a health benefit plan, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association actively engaged in business, that has its principal place of business in this state, and that employed an average of at least one but not more than 50 eligible employees on business days during the preceding calendar year and employs at least one employee on the first day of the plan year.

The number of Eligible Employees does not include those separately covered under a Trust established under the Labor Management Relations Act of 1938.

The definition of Small Employer does not include a sub-unit of a Trust established under the Labor Management Relations Act of 1938 and covering more than 25 members (employees), nor does it include any subsidiary unit of a firm employing more than 25 employees.

Small Employer status is determined during the calendar year immediately preceding the date of the determination. A date of determination may be up to 90 days prior to the effective date of coverage with a Carrier; or, for a policy already in force, the policy's renewal date or rate change date. For existing business, the Carrier shall determine whether or not an employer is a Small Employer annually, and that determination will be maintained for one year from its effective date.

Y. **Small Employer Carrier** means any Carrier which offers Health Benefit Plans covering Eligible Employees of one or more Small Employers, and registered as such with the Office.

Z. **Small Employer Health Benefit Plan** means a Health Benefit Plan for Small Employers, established in accordance with Section (5) of the Small Employer Act.

AA. **Small Employer Reinsuring Carrier** is a reinsuring carrier as defined in Section (9) of the Small Employer Act.

BB. **Small Employer Risk-Assuming Carrier** is a risk-assuming carrier as defined in Sections (9) and (10) of the Small Employer Act.

CC. **Special Enrollment Period** is a period of time, as required in Section 627.65615, F.S., or, if the carrier is an HMO, as required in Section 641.31072, F.S., during which a person may enroll in a Small Employer Health Benefit Plan without being considered a Late enrollee, other than the time during which the individual is first eligible to enroll in the plan.

DD. **HMO** means an organization governed by Chapter 641, Florida Statutes.

Article III - Program Provisions Applicable to Certain Carriers

A. Each Small Employer Carrier designated as a Small Employer Reinsuring Carrier may reinsure coverage under Small Employer Health Benefit Plans and shall be subject to assessment as described in the Small Employer Act. Each Individual Carrier designated as an Individual Reinsuring Carrier may reinsure coverage of Eligible Individuals and Eligible Dependents purchasing coverage required to be offered pursuant to Section 627.6487, F.S., and shall subject to assessment as described in the Individual Act.

B. Small Employer Risk-Assuming Carriers are not Reinsuring Carriers, and they are not subject to Small Employer program assessment except for Board Administrative expenses as provided in the Act. Individual Risk-Assuming Carriers are not Reinsuring Carriers, and they are not subject to Individual program assessment except for Board Administrative expenses as provided in the Acts. Both types of Risk-Assuming Carriers must provide certain information to the Administering Carrier (Article XIV).

C. Carriers who are not registered as Small Employer Carriers or Individual Carriers are subject to second tier assessments (Article XIII).

D. An Administering Carrier may be chosen by the Board to perform certain functions of the Program (Article VIII). If an Administering Carrier is not chosen, these function may be performed by the Executive Director or other contracted entities based on criteria determined by the Board.

Article IV - Powers of the Program

The Program has the general powers and authority granted under the laws of Florida to insurance companies and Health Maintenance Organizations licensed to transact business except the power to

issue Health Benefit Plans directly to groups or individuals. In addition, the Program has the specific authority to:

A. Provide reinsurance and establish rules, conditions, and procedures in accordance with the requirements of the Acts.

B. Establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the Program.

C. Assess Carriers in accordance with the provisions of the Acts, and make interim assessments for reasonable and necessary expenses. Design reports and procedures so required.

D. Adjust the level of claims retained by both types of Reinsuring Carriers, as appropriate.

E. Enter into contracts as necessary or proper to carry out the duties of the Program, including contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

F. Borrow money to effect the purposes of the Program, from Carriers or other institutions. Any notes or evidences of indebtedness of the Program which are not in default constitute legal investments for Carriers and may be carried as admitted assets.

G. Appoint legal, actuarial, and other committees to provide technical assistance in the operation of the Program.

H. Take any legal actions necessary to avoid the payment of improper claims against the Program.

I. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against the Program or any carrier.

Article V - Plan of Operation

A. The Program shall perform its functions under this Plan of Operation (the Plan), and in accordance with the Acts.

B. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and provide for the sharing of Program gains or losses in accordance with the provisions of the Act.

C. The Program operates for the benefit of both types of Reinsuring Carriers who issue coverage as required under the Acts. For Small Employer Reinsuring Carriers, the statutory requirement involves offering a Basic and Standard Health Benefit Plan as well as other Small Employer Health Benefit Plans, to all Eligible Small Employers. For Individual Reinsurance Carriers, the statutory requirement involves offering at least two generally available coverages, as described in section (4) of the Individual Act. The Small Employer Plans and the Individual Plans shall be offered without

regard to health status or claim experience. The Board shall provide additional clarification of Carrier requirements under the Acts, as needed.

D. The Program does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any employer, employee, dependent or other entity or person insured by any Reinsuring Carrier. It does not provide any benefit or create any obligation, contractual or otherwise, to any person or entity other than a Reinsuring Carrier.

Article VI - Board of Directors and Meetings

A. The Program shall exercise its powers through a Board of Directors:

1. The Board shall consist of the Commissioner or his designee (who shall chair the Board) and thirteen additional members. The composition of the Board shall be as described in Subsection (11)(b)3. of the Small Employer Act.

2. The Board may elect a Secretary from among its members, as well as other officers as it deems appropriate, for terms it deems appropriate. If the Board does not elect a Secretary, the Executive Director shall perform those duties required of a Secretary.

3. Vacancies occurring on the Board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

B. The votes of the Board shall be on a one person, one vote basis.

C. A majority of the Directors of the Board shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as provided in Section J below.

D. An annual meeting of the Board shall be held each year. At that meeting, the Board shall:

1. Review the financial results for the prior year, including earned premiums, expenses of Program administration, and incurred losses taking into account investment income and other appropriate items.

2. Determine the Program net losses for both the Individual and Small Employer programs for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate income, and, by March 1, file a report with the Office of the Program net loss for each pool.

3. Determine if an assessment is necessary for the proper administration of the Program, and, by March 1, file an estimate of the needed assessments with the Office.

E. At least once each year, the Board shall meet to:

1. Review this Plan and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports describing financial results, outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

4. Review and approve the rates for Individual and Small Employer reinsurance coverage.

5. Increase the reinsurance deductible to adjust for increases in cost and utilization. Each year, the level of claims retained by both types of Reinsuring Carriers shall be increased by at least the annual change in the medical care component of the Consumer Price Index for All Urban Consumers, unless the Board recommends and the Office approves a lower increase.

6. Review and approve the rate of interest and administrative fee to be charged for late payments.

7. Review and recommend to the Commissioner appropriate changes in market conduct or other requirements for Individual Carriers, Small Employer Carriers and agents, including rules as to the manner and levels of agent compensation for plans required to be provided pursuant to the Acts. Both Individual and Small Employer Carriers shall provide reasonable compensation to agents, if any, in a manner and at a level which considers the need for broad availability of coverage, the objectives of the Program, the time and effort expended in placing the coverage, the need to provide services to employers and eligible individuals, the levels of agent compensation currently used in the industry, and the overall cost of coverage.

   The Board may, if it determines appropriate, provide one or more detailed schedules for compensation, based on these same considerations. Any such schedule shall be subject to approval by the Office. Once approval is granted, the schedule shall be incorporated into this Plan.

8. Develop and approve the Program's Investment Policies, generally consistent with Chapter 625 of Florida Statutes.

9. Review and approve changes, if any, in the communications program.

10. Determine whether any technical corrections or amendments to the Act should be recommended to the Commissioner.

11. Review the effectiveness of the Program in improving rate stability, accessibility, and affordability in the small employer and individual marketplace.

12. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the Program.

F. The Board shall hold other meetings upon the request of the Chairman or of three or more Directors, at appropriate times and frequency. These meetings may be held in

person, by telephone, or by a written vote circulated to the Directors, upon which the Directors will indicate in writing their rejection or approval of the measure at issue. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors at least 7 days prior to the meeting.

G. A written record of the proceedings of each Board meeting shall be made. The original of the record shall be retained by the Secretary of the Board, if such position is created; otherwise, it shall be retained by the Executive Director.

H. The Board may establish administrative rules of practice of the Program consistent with the Acts and this Plan.

I. Under the Acts, the Board has been assigned various other responsibilities relating to Small Employer and Individual access. The Board may undertake, assign, or contract for administration of these duties.

J. Amendments to the Plan or suggestions of technical corrections to either of the Acts shall require the concurrence of a majority of the entire Board.

K. Directors of the Board may be reimbursed from the monies of the Program for reasonable expenses incurred by them as Directors, upon approval of such expenses by the Board, but they shall not otherwise be compensated by the Program for their services. Submission for reimbursement must be received by the Program within 60 days of the actual travel date.

L. Executive Director

1. The Board may select and hire or contract for an Executive Director who will assist the Board and who shall be assigned the responsibility for ensuring that the day-to-day functions related to execution of the Plan are completed. The Board may also hire or contract for additional administrative staff support.

2. With Board supervision, the Executive Director shall be in charge of the business management activities in the daily operation of the Program and shall be responsible for staffing and facilitating services to the Board.

3. At least annually, the Board shall review the performance of the Executive Director to ensure the Executive Director's compliance with the requirements of the Plan and the performance of its duties. At this time, the Board shall review the Executive Director's compensation and shall determine whether any adjustments are appropriate. The Chairman of the Board shall meet with the Executive Director and inform the Executive Director of the Board's review and determinations.

Article VII – Conflict of Interest, Ethics

To ensure that the Program and its Board are free from potential conflict or inappropriate behavior, the following guidelines for conduct of the Board members and all contractors, agents, and employees of the Plan are hereby adopted:

A. Each Board member, contractor, agent or employee shall have an affirmative duty to notify the Board and the Office if the member, contractor, agent or employee, or carrier that the Board member represents, has a potential conflict of interest.

B. No Board member, contractor, agent, or employee, shall use their position to foster or facilitate any pecuniary gain for themselves, their member carrier(s), or any other entity in which the Board member, agent or employee, or the member carrier has a substantial financial interest.

C. No Board member, contractor, agent, or employee, shall use their position to secure or promote any business relationship from which they may derive a financial gain.

D. All Board members, contractors, agents, and employees shall be subject to the following restrictions regarding the receipt of gifts:

1. In connection with the conduct of official Board business, Board members, contractors, agents and employees may not accept meals (including cocktails parties, receptions and the like) from a person doing business with the Program or from any political committee or committee of continuous existence as defined by section 106.011, Florida Statutes; or from a lobbyist who lobbies the Program, or any partner, firm, employee or principal of such person, committee, or lobbyist.

2. The restrictions specified above are not intended to prohibit a contractor, agent or employee from accepting compensation from a client or employer with respect to services provided which are not in any way related to the business of the Program. This provision is not intended to relieve the contractor, agent or employee of the affirmative duty of disclosure provided in A. above.

3. The restrictions specified above are not intended to prohibit a Board member, contractor, agent or employee from receiving any type of compensation that the Board member, contractor, agent or employee might receive from his or her employer for the performance of his or her duties.

E. Neither the Executive Director nor any member of the Board shall personally represent another person or entity for compensation before the Board for a period of two years following vacation of the position, unless employed by an agency of state government.

F. All contracts entered into for services after January 1, 2005, shall be accompanied by a disclosure form requiring the vendor to disclose any relationships, financial or otherwise, with any employee or member of the Board, and placing the vendor on notice of the conflict of interest policy applicable to contractors, agents or employees of the Program, including the limitation on gifts.

G. Any breach of conflict of interest, post-employment restrictions, other ethics policies or suspected fraud or compromise of public trust by the Executive

Director or members of the Board shall be reported by the executive Director to the Chair of the Board immediately upon discovery. If such breach constitutes potential criminal activity, the full circumstances shall also be reported by the Executive Director to the Department of Financial Services, Division of Insurance Fraud within 48 hours of discovery.

Article VIII - Committees

Each Director shall be entitled to participate personally on any committee established by the Board, or, with Board approval, to appoint another voting member. A written record of the proceedings of each committee shall be maintained by a Secretary appointed from the membership of the committee or by the Executive Director.

Committees may include the following:

A. Actuarial Committee

When directed by the Board, the mission of the Actuarial Committee includes the following:

1. Recommend to the Board appropriate reinsurance premium rates, rate schedules, rate adjustments, and rate classifications for individuals and groups reinsured with the Program.

2. Recommend to the Board the appropriate increase in reinsurance deductibles, recognizing both cost and utilization increases, as described in Section (11)(g) of the Small Employer Act and Section (7) of the Individual Act.

3. Determine the incurred claims of the Program, including amounts for incurred but not reported claims.

4. Recommend to the Board appropriate method(s) for reinsurance of Plans other than the Basic and Standard Plans.

5. Recommend to the Board reports to be made by Reinsuring Carriers and the Administering Carrier, if any.

6. Recommend HMO adjustments to both Reinsurance Premiums and Claims.

7. Review the methods for calculating assessments and recommend any needed revisions to the Board.

8. Calculate the Carrier premiums to be used in determining assessment amounts.

9. Develop and recommend to the Board, for use in determining reinsurance premiums for Reinsuring Individual Carriers, a standard HMO Individual Health Benefit Plan and a standard high benefit indemnity Individual Health Benefit Plan ("High Benefit Plan") and a standard low benefit indemnity Individual Health Benefit Plan ("Low Benefit Plan").

10. Provide reports and other recommendations as directed by the Board.

B. Audit Committee

When directed by the Board, the mission of the Audit Committee includes the following:

1. Develop a uniform audit program to be utilized by independent auditors in their review of items related to reinsurance with the Program and assessments for each affected Carrier. The audit program shall include a requirement that the independent auditor verify a representative sample of statements containing the certificates and acknowledgments listed in Section (12)(d)2. of the Small Employer Act.

2. Establish standards of acceptability for the selection of the auditing firm(s).

3. Assist the Board in the selection of an independent auditor for the annual audit of the Program operations.

4. Assist the Board in the review of the reports prepared by the independent auditors in conjunction with 1. and 3. above and any other audit-related matters the Board deems necessary.

5. Oversee the proper conduct of activities by the Administering Carrier, if any.

C. Other committees may be appointed as deemed necessary by the Board.

Article IX - Administering Carrier: Selection and Duties

If the Board selects an Administering Carrier, the Administering Carrier shall be jointly responsible, with the Board, the Executive Director and all Small Employer Carriers, for the fair, equitable, and reasonable administration of the Program.

A. The selection of an Administering Carrier shall be based upon a selection process approved by the Board. The Administering Carrier must be either a Carrier or a third party administrator approved to operate in the State of Florida.

B. An Administering Carrier shall perform functions as directed by the Board and outlined in this Plan, including:

1. Establish procedures and install the systems needed to administer the operations of the Program in accordance with the Acts and this Plan:

   a. Accept, on behalf of the Program, risks that are ceded by Reinsuring Carriers.

   b. On a timely basis, collect reinsurance premium for ceded risks and all other amounts due to the Program. Unless modified by the Board, a "timely basis" is defined to mean receiving premium within 30 days of due date. If the premium is not received within 10 days after the 30 days expires, the Administering Carrier, if any, shall send a late notice demanding payment (including interest and penalties if

appropriate) within 20 days. The Administering Carrier, if any, shall be notified in writing of any modification to this time schedule by the Board.

c. Design forms for reinsurance reporting and submit the proposed forms to the Board for approval.

d. Process and prepare for payment reinsurance claims paid on ceded risks.

2. Establish a lock box in the name of the Administering Carrier, if any, for all premium income of the program. The financial receipts of the Program shall be timely deposited into one or more accounts maintained in the name of the Program.

3. Prepare and maintain all assigned financial records consistent with sound business practices prescribed or permitted by the Board. The financial accounting system employed by the Administering Carrier, if any, must establish and provide a clear audit trail of all financial transactions handled by and records prepared by the Administering Carrier, if any.

4. Perform other functions as directed by the Board.

C. An Administering Carrier shall maintain all Program records for a period of 7 years following the end of the year. All such records are the property of the Program and shall be delivered to the Board upon demand.

D. An Administering Carrier shall serve until the appointment by the Board of a successor Administering Carrier, until its resignation, or until it is otherwise removed or terminated by the Board or by the Director. An Administering Carrier shall give the Board 180 days notice of its decision to resign. The Board shall give an Administering Carrier 90 days notice of its decision to remove or terminate the Administering Carrier without cause.

E. An Administering Carrier may subcontract for services, but must obtain the Board's approval whenever a single subcontractor is to be paid more than $25,000 in any year.

F. In performing its duties, an Administering Carrier shall maintain the confidentiality of all information pertaining to insureds and Reinsuring Carriers, in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets.

Such information shall be used only for the purposes necessary for the operation of the Program, and shall be strictly segregated from other records, data, and operations of an Administering Carrier. Unless specifically required here, under the Acts, or under other applicable laws, no information shall be retained or used by an Administering Carrier or disclosed to any third party, if it identifies a specific insured or Reinsuring Carrier.

Article X – Small Employer Eligibility for Reinsurance

Small Employer Reinsurance is available only for coverage of Eligible Employees and Eligible Dependents under Eligible Health Benefit Plans issued by Reinsuring Carriers to Eligible Small Employers as described in the Small Employer Act and in this Article. A Small Employer Reinsuring Carrier may reinsure with the Program the coverage of:

- an individual Eligible Employee and/or Eligible Dependents, or
- an Eligible Small Employer's entire group of Eligible Employees and Eligible Dependents.

A. Identifying Eligible Small Employers

1. Small Employer status is determined as of the effective date of a Small Employer Carrier's coverage of a firm's Health Benefit Plan. New employees added to Health Benefit Plans in force are also eligible, if all other applicable conditions are met.

2. The determination of the number of Eligible Employees may be based on the most recent Federal or State filing which reflects the number of full-time employees, accompanied by a Small Employer certification of this information, unless the Small Employer submits other verifiable information to the Small Employer Carrier.

3. Access regardless of health status is provided and reinsurance is available to Reinsuring Carriers, only if the Small Employer satisfies eligibility, contribution, and participation requirements specified in the Small Employer Carrier's Health Benefit Plan. The Carrier's requirements must comply with the limitations described in Section (5) of the Small Employer Act.

4. Each Small Employer Carrier is responsible for determining whether a firm is an Eligible Small Employer as of the effective date of coverage, for updating that determination each year, and for obtaining information from the Small Employer to document that determination.

   The Reinsuring Carrier is also responsible for certifying the above determination to an Administering Carrier or to the Program if any coverage under a Small Employer's Health Benefit Plan is to be reinsured. If a Reinsuring Carrier, while acting in good faith, erroneously certifies a firm to be an Eligible Small Employer, reinsurance of any employees of that firm, or their dependents, shall be terminated within 30 days after an Administering Carrier or the Program is notified of the error.

B. Identifying Eligible Health Benefit Plans

1. The status of a Small Employer Health Benefit Plan is determined in Section (5) of the Small Employer Act. It is unaffected by whether the Small Employer provides health benefits by purchasing a group policy, by participating in a Multiple Employer Welfare Association or a plan sponsored by a trade association, by buying coverage under individual health policies for employees, or by paying benefits directly to employees from its own funds. It is also unaffected by employees' coverage under Medicare.

2. For Basic and Standard Plans, the Program will reinsure the level of coverage provided to the employee subject to the reinsurance deductible and coinsurance amounts specified in Article XI of this Plan. Reinsurance is not available if riders, endorsements, or other means are used to restrict or exclude coverage for specified diseases or medical conditions, under either the Basic or Standard Plan.

3. For other plans, the Program will reinsure the level of coverage provided to the employee up to, but not exceeding, the level of coverage provided in a Basic or Standard Plan, whichever is initially specified by the Reinsuring Carrier and is consistent with paragraph XI D.2.d. of this plan.

C. Identifying Eligible Employees and Dependents

1. If a Small Employer Carrier offers coverage to a Small Employer, it must offer coverage to all the Small Employer's Eligible Employees and Eligible Dependents. A Small Employer Carrier may not offer coverage limited to certain persons in a group, except with respect to Late Enrollees.

2. Coverage of Extra Insureds and their dependents does not qualify for reinsurance.

3. Reinsurance does not cover any excludable Pre-existing Condition to the maximum extent allowed under the Small Employer Act, if allowed by applicable federal and state law.

4. Any material statement by an employer or employee, which falsely certifies as to an individual's eligibility for coverage, constitutes cause for termination of reinsurance, without penalty to the Reinsuring Carrier.
Prompt notice of the discovery shall be made to the Administering Carrier and reinsurance of any such individuals shall be terminated within 30 days of the notification.

D. Late Enrollee Provisions

1. For the purpose of determining Late Enrollee status, the initial enrollment period refers to the enrollee's earliest opportunity to enroll for coverage under any Health Benefit Plan sponsored by the employee's current Small Employer.

2. For Small Employers with fewer than two Eligible Employees, a Small Employer Carrier may decline coverage for a Late Enrollee, but only for a period not exceeding 24 months from the Late Enrollee's application and only if the Late Enrollee was not covered by creditable coverage continually to a date not more than 63 days before the effective date of the new coverage. Reinsurance is not available during this period.

3. A Small Employer Carrier may exclude coverage of a pre-existing condition while accepting a Late Enrollee's application, unless prohibited by applicable state or federal law. During this period, which may not exceed 18 months for Small Employers with two or more Eligible Employees or 24 months for

Small Employers with fewer than two Eligible Employees, reinsurance does not cover claims due to the excluded pre-existing condition.

4. If both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a Late Enrollee, the combined period may not exceed 18 months from the date of the Late Enrollee's application for coverage (24 months for Small Employers with fewer than two Eligible Employees).

5. A Small Employer may change Carriers while a Late Enrollee's coverage or pre-existing condition is excluded. When this occurs, the new Carrier may continue to exclude coverage of the Late Enrollee or of the pre-existing condition, but only for a period of time which ends no later than 18 months from the original date of application with the prior Carrier (24 months for Small Employers with fewer than two Eligible Employees).

6. An Employee or Dependent who enrolls during a Special Enrollment Period is not considered a Late Enrollee.

Article XI – Individual Eligibility for Reinsurance

Individual Reinsurance is available only for coverage of Eligible Individuals and Eligible Dependents under Eligible Health Benefit Plans issued by Individual Carriers to Eligible Individuals as described in the Individual Act and in this Article. An Individual Reinsuring Carrier may reinsure with the Program the coverage of an Eligible Individual and the Individual's Eligible Dependents.

A. Identifying Eligible Individuals

1. Eligible Individual status is determined as of the date on which an individual seeks coverage pursuant to Section 627.6487, F.S.

2. Access regardless of health status is provided and reinsurance is available to Reinsuring Carriers, only if the individual satisfies eligibility requirements specified in the Individual Carrier's Health Benefit Plan. The Carrier's requirements must comply with the limitations described in Section 627.6487, F.S.

3. Each Individual Carrier is responsible for determining whether an individual is an Eligible Individual as of the effective date of coverage and for obtaining information from the eligible Individual to document that determination.

   The Reinsuring Carrier is also responsible for certifying the above determination to the Administering Carrier, if any coverage under an Individual Health Benefit Plan is to be reinsured. If a Reinsuring Carrier, while acting in good faith, erroneously certifies an individual to be an Eligible Individual, reinsurance of that individual shall be terminated within 30 days after an Administering Carrier or the Program is notified of the error.

4. When an Individual Carrier offers coverage to an Eligible Individual, if the plan offered covers dependents, the coverage must be offered to all of the Eligible Individual's Eligible Dependents. If the dependent is not also an

Eligible Individual, the Plan may impose a Pre-existing Condition Limitation, unless prohibited by applicable state or federal law.

5. An Individual Carrier may nonrenew or discontinue coverage if the individual has failed to pay premiums or the carrier has failed to receive timely premiums, the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage. Prompt notice of the discovery shall be made to an Administering Carrier or to the Program, and reinsurance of any such individuals shall be terminated within 30 days of the notification.

B. Identifying Eligible Health Benefit Plans

1. Individual Health Benefit Plans required to be provided are described in Section 627.6487(4), F.S.

2. If the Individual Health Benefit Plan offered to Eligible Individuals provides family coverage (coverage for dependents), the Individual Carrier must offer coverage under the Plan to all Eligible Individuals' Eligible Dependents. If the Individual Health Benefit Plans required to be provided pursuant to Section 627.6487(4), F.S., do not provide family coverage, the Individual Carrier is not required to offer family coverage Health Benefit Plans to Eligible Individuals.

3. As described in Article XI of this Plan, the Program will reinsure the level of coverage provided to the Eligible Individual up to, but not exceeding, the level of coverage provided in the HMO Individual Health Benefit Plan, the indemnity High Benefit Plan, or the indemnity Low Benefit Plan.

Article XII – Procedures for Ceding Risks

A. Reinsurance Rules and Premium Levels

1. Each Reinsuring Carrier proposing to cede reinsurance of the coverage for any group, individual member of the group, or an Eligible Individual or Eligible Dependent is responsible for ascertaining and certifying that:

a. if group coverage, the ceded group is an Eligible Small Employer;

b. if group coverage, the ceded individual is an Eligible Employee or an Eligible Dependent;

c. if Individual Coverage, the ceded individual is an Eligible Individual or Eligible Dependent;

d. the Plan meets all other requirements of the applicable Act; and

e. the reinsurance premium rate payable to the Program for that group, individual member of the group, or an Eligible Individual has been correctly determined in accordance with this Article.

Each Reinsuring Carrier must document these determinations in reporting reinsurance census data and reinsurance premiums to an Administering Carrier or to the Program.

2. A Small Employer Reinsuring Carrier may cede an entire group (all covered employees) under a Small Employer Health Benefit Plan. Alternatively, a Small Employer Carrier may cede individual coverage for a specific Eligible Employee or Eligible Dependent (or an Eligible Employee's dependents as a unit) under a Small Employer's plan.

   Reinsurance of an entire group can be effective only as of one of the following dates:

   a. the initial effective date of the Eligible Small Employer's plan; or,

   b. the effective date of transfer of the group from a prior Carrier.

   Reinsurance of an individual covered under an Eligible Small Employer's plan may be effective either on one of the above dates or on the effective date of the individual's coverage, if later.

   A renewal, re-issue, attainment of policy anniversary, amendment, rider, or other change in the Small Employer's Health Benefit Plan or individual Health Benefit Plan does not serve to qualify an individual or group for reinsurance.

   Reinsurance of an Eligible Individual covered under an Individual Carrier's Health Benefit Plan may be effective on the date such coverage begins.

3. Availability of reinsurance is subject to the following additional rules:

   a. If Small Employer coverage, the ceded group must be an Eligible Small Employer on the effective date of reinsurance.

   b. If Small Employer coverage, each ceded individual whose coverage is reinsured must be an Eligible Employee or Eligible Dependent.

   c. Formerly part-time, temporary, or substitute employees may be reinsured as of the date of transfer to Eligible status (insurance effective date).

   d. A Reinsuring Carrier may change the reinsurance status of a reinsured Small Employer group during a policy year, from reinsurance of the entire group to reinsurance of only selected individual(s) in the group. If an entire group's coverage is reinsured and the Carrier does not elect this status change, all newly Eligible Employees and Eligible Dependents must be reinsured.

   e. The Reinsuring Carrier may reinsure individual coverage of an Eligible Employee without reinsuring coverage of any specific Dependent of that employee, and may reinsure coverage of a specific Eligible Dependent without reinsuring coverage of the Employee. A

newborn's coverage may be reinsured only if the mother's coverage was reinsured prior to the date of birth.

f. If Individual coverage, the individual must be an Eligible Individual or Eligible Dependent.

B. Notification of Reinsurance

1. For reinsurance to become effective, notice must be provided to an Administering Carrier or to the Program within 60 days after the effective date of the group's, employee's, dependent's or Eligible Individual's coverage. Notice must include all required information with respect to those whose coverage is to be reinsured.

2 An Administering Carrier or the Program may grant exceptions to newly designated Reinsuring Carrier. With a valid, written explanation, notification of a Carrier's first reinsured group or individual may be accepted up to 21 days beyond the normal 60-day notice. An Administering Carrier will report any such exception to the Board.

3. For unusual circumstances, including fraudulent reporting to the carrier of the health status of the Eligible Employee, Eligible Dependent, or Eligible Individual, the Board may (although it is not required to do so) extend the 60-day notice period. If a Reinsuring Carrier believes that, through no fault of its own, it was unable to appropriately review the health status of the covered individuals in a timely manner, the Carrier may petition the Board for an extension of the notice period. If the Carrier so petitions the Board, it must notify the Board as soon as possible after discovering the circumstance. In determining whether to extend the notice period, the Board shall take into account the number of requests for extensions of time made by a specific carrier.

C. Period of Reinsurance

1. Reinsurance may continue for as long as the Eligible Employee's and/or Eligible Dependent's or the Eligible Individual's coverage remains in effect under an Eligible Small Employer or Eligible Individual Health Benefit Plan.

2. For group coverage, when the number of Eligible Employees increases to more than 50, reinsurance may be continued until the first of the following occurs:

a. The number of Eligible Employees reaches 55 as of the date of the Small Employer Carrier's annual determination. (See Article II-Z.)

b. The number of Eligible Employees exceeds 50 for two consecutive annual determination dates.

c. The Small Employer Carrier takes a rating or access action which would be prohibited for a group of 50 or fewer Eligible Employees.

3. A Reinsuring Carrier may withdraw a group or individual from the Program while coverage continues under the Small Employer or Eligible Individual's plan. Written notice must be provided at least 30 days in advance of the withdrawal.

4. For group coverage, reinsurance of an individual's coverage ceases at the termination of the individual's status as an Eligible Employee or Eligible Dependent (e.g., at retirement or other termination of active employment, divorce of a spouse, or a child's attainment of limiting age), except to the extent that coverage under the Small Employer Health Benefit Plan continues as required by law. If the Reinsuring Carrier provides coverage for such persons beyond that date, for contractual or other reasons, reinsurance will be available for a maximum of an additional 30 days.

5. Reinsurance ceases for an individual covered under a Small Employer's Health Benefit Plan (including an individual whose coverage under that plan has continued as required by law) at termination of the Reinsuring Carrier's coverage of the group.

6. A Small Employer Carrier or Individual Carrier who becomes a Risk-Assuming Carrier is no longer a Reinsuring Carrier, and is prohibited from reinsuring or continuing to reinsure coverage under any Small Employer Health Benefit Plan or Individual Plan.

D. Determination of Reinsurance Premium

1. Using the procedures outlined below, the Board shall develop tables of reinsurance premium rates. These rates shall be submitted to the Office for its approval and then communicated to Reinsuring Carriers. The Board shall review the rates from time to time and revise them to reflect the claims experience of the Program. Such revisions shall be implemented after approval of the Office.

2. For the Small Employer Carrier portion of the Program, the reinsurance premium rates will be determined as follows:

   a. For any reinsured individual, the reinsurance premium is 500% of the basic rate established for that rate classification and coverage.

   b. For any reinsured group, the reinsurance premium is 150% of the total basic rate established for that group reflecting both the rate classification of each reinsured unit within the group and coverage.

   c. The basic rates will be established taking into account the following:

      (1) Approximations of premiums charged to Eligible Small Employers by Small Employer Carriers for Health Benefit Plans with benefits similar to the Basic and Standard Health Benefit Plans;

      (2) Case characteristics commonly used by Small Employer Carriers in Florida;

(3) Consideration of usual actuarial criteria for establishing premium rates for Small Employers;

(4) Adjustments to recognize the benefits portion of premium, as well as the reinsurance deductible and coinsurance;

(5) Adjustments to recognize the use of managed care mechanisms, including the use of restrictive provider networks; and

(6) Adjustments to recognize the presence of stop loss insurance.

d. Reinsurance rates vary by plan:

(1) Under policy forms with benefits valued below the most recent "Basic" plan, reinsurance premiums will be those for Basic. Reinsured claims will be determined according to actual payments under the policy form.

(2) For policy forms the benefits valued between the most recent "Basic" and "Standard" plans, the reinsurance premiums will be those for Standard. Reinsurance claims will be determined according to actual benefits under the policy form.

At the option of the carrier, reinsurance premiums for Basic may be applied. If the carrier so elects, reinsurance claims must be determined according to Basic plan benefits, rather than those under the actual policy form.

3. For the Individual Carrier portion of the Program, the reinsurance premium rates will be determined as follows:

a. For any reinsured individual, the reinsurance premium is 500% of the basic rate established for that rate classification and coverage.

b. The basic rates will be established taking into account the following:

(1) Approximations of gross premiums charged to Eligible Individuals by Individual Carriers for Health Benefit Plans similar to the standard HMO Health Benefit Plan and the indemnity Individual Health Benefit Plans developed by the actuarial committee (the High Benefit Plan and the Low Benefit Plan);

(2) Case characteristics commonly used by Individual Carriers in Florida;

(3) Consideration of usual actuarial criteria for establishing premium rates for Health Benefit Plan coverage for individuals;

(4) Adjustments to recognize the benefits portion of premium, as well as the reinsurance deductible and coinsurance;

(5) Adjustments to recognize the use of managed care mechanisms, including the use of restrictive provider networks; and

(6) Adjustments to recognize the presence of stop loss insurance.

c. Reinsurance rates vary by plan:

(1) For HMO coverage, reinsurance premiums will be those determined for the HMO plan of reinsurance using the standard HMO Health Benefit Plan developed by the actuarial committee.

(2) Under policy forms with benefits valued below the Low Benefit Plan, reinsurance premiums will be those determined for the Low Benefit Plan. Reinsured claims will be determined according to actual payments under the policy form.

(3) For policy forms with benefits valued between the Low Benefit Plan and the High Benefit Plan, the reinsurance premiums will be those for the High Benefit Plan. Reinsurance claims will be determined according to actual benefits under the policy form.

(4) For policy forms with benefits valued above the High Benefit Plan, the reinsurance premiums will be those for the High Benefit Plan. Reinsurance claims will be determined according to the High Benefit Plan benefits, rather than those under the actual policy form.

(5) At the option of the Carrier, reinsurance premiums for the Low Benefit Plan may be applied. If the carrier so elects, reinsurance claims must be determined according to the Low Benefit Plan benefits, rather than those under the actual policy form.

4. The Board may, subject to Office approval, implement premium rate table adjustments for Reinsuring Carriers using case management or other specific cost containment measures or to recognize the presence of stop loss insurance.

5. The Eligible Employees of an Eligible Small Employer may change during a year when some Employees and/or Eligible Dependents have been reinsured as individuals. A Small Employer Reinsuring Carrier is not required to pay reinsurance premium for covered individuals, beyond the amount which would have been paid if all Eligible Employees and Eligible Dependents had been reinsured as an entire group.

E. Billing and Payment

1. Premiums are determined as of the first of the month and are due by the twentieth of the month, for the applicable month.

   Interest on late premiums will be charged at 1.5% per month.

2. The reinsurance premiums charged to Small Employer Reinsuring Carriers for each group or individual will be determined by the Table of Rates in effect on the later of the effective date of the Small Employer's Health Benefit Plan with the Reinsuring Carrier or the most recent plan anniversary. The reinsurance premiums charged to Individual Reinsuring Carriers for each reinsured Eligible Individual or Eligible Dependent will be determined by the Table of Rates in effect on the later of the effective date of the individual's Health Benefit Plan with the Individual Reinsuring Carrier or the most recent renewal date.

3. Reinsurance bills will be handled on a "self-billed" basis. Monthly, the Reinsuring Carrier will provide an Administering Carrier or the Program with a list of groups and individuals reinsured (as applicable), the premium for each individual (for the month covered), and such other information as may be required by the Program.

   If the premium is incorrect as calculated by an Administering Carrier or the Program, an Administering Carrier or the Program will deny the submission if the individual is a newly reinsured individual. The Reinsuring Carrier will be notified of the error and that submission of the life is denied. The Reinsuring Carrier will be refunded any related premium. The Reinsuring Carrier will have 90-days to resubmit the correct premium.

   If the premium for an existing reinsured is incorrect, an Administering Carrier or the Program will notify the Reinsuring Carrier of the error. The Reinsuring Carrier will have 90 days to submit the correct premium. Pending receipt of the correct premium, all claims payments to this Reinsuring Carrier will be suspended. If the Reinsuring Carrier does not correct the premium, the ceded life will be terminated retroactive to the data the error was discovered and all related premium will be refunded. No claim payments will be processed during this 90-day period.

4. Reinsurance premium amounts are to be based on whole month increments only. If reinsured coverage is effective during the first 15 days of the month, the entire month is paid in full. When coverage becomes after the 15th of the month, no premiums will be payable until the first month following the effective date.

5. Terminations effective during the first 15 days of the month will be allowed refunds for the entire month, and terminations effective after the 15th of the month will not be allowed a premium refund.

6. Reinsurance premium is due to the Program for as long as the Benefit Plan remains in force, regardless of the Reinsuring Carrier's ability to collect the

Small Employer's or Eligible Individual's premiums. The Program has no responsibility for the Reinsuring Carrier's collection of premiums.

Article XIII - Reinsurance Claims

A. Statement of Reinsurance

After the deductible, the Program will indemnify both Individual and Small Employer Reinsuring Carriers for 90% of the first $50,000 of Covered Claims, 95% of the next $100,000 of Covered Claims, and 100% of the excess, as described in the Acts, and subject to the following:

1. Covered Claims are amounts in excess of the deductible amount in benefit payments made by the Reinsuring Carrier, for services provided during a calendar year for a reinsured Eligible Employee, Eligible Dependent, or Eligible Individual.

2. Coverage provided by Small Employer Reinsuring Carriers under Plans other than the Basic or Standard Benefit Plans shall be reinsured up to the lesser of the benefits provided under the other plan or the Basic or Standard Plan for which reinsurance premiums have been paid.

3. For the purposes of this section, "Covered Claims" shall mean only amounts actually paid by Reinsuring Carriers for benefits provided for individuals reinsured by the Program. Covered Claims shall not include:

   a. Claim adjudication expenses.

   b. Salaries paid to employees of Reinsuring Carriers who are not also providing health care services directly to Eligible Employees, Eligible Dependents or Eligible Individuals.

   c. Court costs, attorney's fees or other legal expenses.

   d. Any amount paid by Reinsuring Carriers for:

      (1) Punitive or exemplary damages; or

      (2) Compensatory or other damages awarded to the insured arising out of the conduct of the Carriers in the investigation, trial, or settlement of any claim for failure to pay or delay in payment of any benefits under any policy; or

      (3) Compensatory or other damages awarded to the insured arising out of the operation of any managed care, cost containment, or related programs.

   e. Any statutory penalty imposed upon a Reinsuring Carrier.

B. General Requirements

1. Reinsuring Carriers agree that they will promptly investigate, settle, or defend all claims arising under the risks reinsured and that they will forward copies of such reports of investigation promptly, as may be requested by an Administering Carrier or the Program.

2. Reinsuring Carriers will adjudicate all claims on ceded individuals. They will be required to assure that their claim management practices are consistent for reinsured and non-reinsured individuals. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

3. Reinsuring Carriers agree to use their usual case management and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions consistent with both non-reinsured and reinsured business. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

4. The Program shall have the right, at its own expense, to participate in the investigation, adjustment or defense of any claim.

5. The Program shall have the right to inspect the records of the Reinsuring Carrier in connection with reinsured individuals. The Reinsuring Carrier shall submit any additional information required in connection with claims submitted for reimbursement. Carriers shall secure necessary authorizations from insureds for this purpose.

6. All information disclosed between the Program (or an Administering Carrier) and Reinsuring Carriers, in connection with the Program, shall be considered to be proprietary information by the Carriers and by the Program.

7. If any payment is made by the Program and the Reinsuring Carrier is reimbursed by another party for the same expenses, any reinsured claims shall be appropriately adjusted. The Reinsuring Carrier shall do whatever is necessary to preserve and secure its usual reimbursement rights.

8. The Program will reimburse a fee for service equivalent for those services that are rendered by Reinsuring Carriers for which there is no fee charged due to a capitation or similar arrangement, provided that any such fee for service equivalent should be calculated by a methodology that has been recommended by the Actuarial Committee and approved by the Board.

9. Except as approved by the Board, reinsurance will be provided only for covered claims submitted within six months after the date the claim is paid.

10. A 60-day re-submission period exists for claims denied by an Administering Carrier or the Program. If the Reinsuring Carrier determines that the 60-day period is insufficient and this re-submission deadline cannot be met, the Reinsuring Carrier must notify an Administering Carrier or the Program in writing. This written notification must include a description of the circumstances involved, as well as the reason for the extension request. Such requests will then be presented to the board for review. When a claim is

denied, an Administering Carrier or the Program shall notify the Reinsuring Carrier that the claim is denied. The notice shall include the reason(s) for denial, a statement that the Reinsuring Carrier has 60-days to resubmit the claims with information necessary to process the claim and information on submitting a request for an extension to the 60-day resubmission period. During this 60-day period or any extension thereof, an Administering Carrier or the Program shall maintain a record of the claim.

C. Claims Reporting

1. Within 20 days after the close of each month, the Reinsuring Carrier shall furnish to an Administering Carrier or the Program the information required with respect to reinsured losses during the period. The information shall be conveyed using forms approved by the Board and furnished by an Administering Carrier or the Program.

2. Each Reinsuring Carrier shall notify an Administering Carrier or the Program as soon as reasonably possible if claims for a reinsured individual are expected to exceed $100,000.

Article XIV – Assessments and Procedures for Collecting Assessments

A. Net Fund Earnings

Each year, net earnings for both the Individual and Small Employer programs of the Program shall be determined separately. Net earnings equal earned reinsurance premiums plus investment income plus prior net earnings, minus incurred claims, expense allowances paid, and taxes incurred. If the net earnings are negative (i.e., this portion of the Program has operated at a loss), the loss shall be recovered by assessments from applicable Carriers as set forth in (B) and (C) below. If the net earnings are positive, no assessment shall be made and the earnings shall be retained by the Program to offset future losses.

B. Assessments on Reinsuring Carriers (First Tier)

Losses shall initially be allocated to Reinsuring Carriers based on their share of Small Employer or Individual Earned Health Benefit Plan premiums, as appropriate, for the applicable calendar year or other assessment period. Status as a Reinsuring Carrier shall be determined as of the last day of the period. For Carriers who become Risk Assuming during the year, their share of Small Employer or Individual earned premiums shall be included only for the period prior to becoming Risk Assuming.

The first tier of assessments shall be determined by multiplying the losses by a fraction.

1. For Small Employer program first tier assessments, the numerator of the fraction equals the Small Employer Reinsuring Carrier's earned premium pertaining to direct writings of Small Employer Health Benefit Plans in Florida. The denominator equals the total of all such premiums earned by Small Employer Reinsuring Carriers. Premiums shall be those earned under both new and existing Small Employer Health Benefit Plans during the

calendar year for which the assessment is made. The maximum First Tier Assessment shall be 5% of each Carrier's Small Employer premiums.

2. For Individual program first tier assessments, the numerator of the fraction equals the Individual Reinsuring Carrier's earned premium pertaining to direct writings of Health Benefit Plans provided to Individuals in Florida. The denominator equals the total of all such premiums earned by Reinsuring Individual Carriers. Premiums shall be those earned under both new and existing Health Benefit Plans provided to Individuals during the calendar year which the assessment is made. The maximum First Tier Assessment shall be 5% of each Carrier's Individual premiums.

First Tier assessments paid by Reinsuring Carriers are credited against any Residual Assessments.

C. Residual (Second Tier) Assessments

The loss for a calendar year in either or both the Small Employer and Individual portions of the Program may exceed the maximums described in Paragraph B of this Article for all of the appropriate Reinsuring Carriers combined. If it does, the excess shall be allocated in proportion to total premiums earned in Florida from all other individual and group Health Benefit Plans and arrangements, except those of Risk-Assuming Carriers in the appropriate market. The second tier of assessments shall be based on the premiums that all Carriers, except Risk-Assuming Carriers in the appropriate market, earned in the calendar year for which the assessment is made, on all Health Benefit Plans. In no event may this Second Tier allocation exceed 0.5% of each Carrier's Health Benefit Plan premiums. Carriers that are risk assuming carriers in either the Small Group market or the Individual market, but not the both, are subject to second tier assessments for the program in which they are not risk assuming. Carriers that are risk assuming in both markets are not subject to second tier assessments. In a calendar year, if a Carrier's first tier assessment exceeds 0.5% of that Carrier's Health Benefit Plan premiums, the Carrier must pay the entire first tier assessment but is not required to pay any second tier assessment for that calendar year.

If losses remain after second tier assessment, the Board shall analyze Program operations to determine necessary corrections, and report its findings for the prior year to the Office by April 1.

D. Assessment Deferral

On application to the Office, assessments may be deferred whenever a Carrier's statutory net worth is at or below the minimum required. The deferral will continue for the period approved or until the Carrier's net worth exceeds statutory requirements. When the deferral period is over, the Carrier must pay the accumulated assessments in installments determined by the Board over a three-year period, and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments. No interest will be charged on deferral for financial impairment.

If an assessment against a Carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other Carriers. When paid, the delayed assessments will be treated as other income to the Program.

E. De Minimus Assessments

Any assessment of less than $10 shall be forgiven.

F. Late Payments

Assessments shall be paid when billed. Second notices are sent if an assessment is delinquent more than two months from the date originally billed. If the assessment is not received by the Program within 30 days of the billing date, the Carrier shall pay interest on the assessment from the 31st day after the original billing date at the rate of 1.5% per month. In the case of a Reinsuring Carrier, the Board may suspend reinsurance rights including payment of all claims if payments are not made within 45 days of the billing date.

G. Earned Premium

Earned premium shall include all premiums, fees, and/or subscriber payments for Health Benefit Plans earned during an accounting period. In lieu of earned premiums, Multiple Employer Welfare Arrangements may report claim payments made and administrative expenses incurred during the accounting period.

H. Board's Administrative Assessment

All risk-assuming and reinsuring carriers shall be assessed to finance the operating expenses of the Board and its office as provided in sub-section (11)(n) of the Small Employer Act and sub-section (7)(f) of the Individual Act.

I. Interim Assessments

In the event of an interim assessment, the Board shall determine a method of allocation consistent with the Acts and with this Article.

J. Assessment Administration

All assessments shall be administered by the Board including assessment notifications to carrier, receipt of assessment payments and disbursement of funds as determined by the Board.

Article XV - Reporting Requirements

A. All Carriers

1. In addition to Statutory Annual Statements, certain other reports shall be submitted by Carriers to the Office. These reports shall be designed with the advice of the Board, and shall be used in calculating assessments.

2. The Program shall notify an Administering Carrier, if any, upon the election to become a risk-assuming or reinsuring carrier by a Small Employer Carrier,

as provided in the Small Employer Act or by an Individual Carrier, as provided in the Individual Act, including the approval date and period of election.

3. The Board shall determine the amount of assessment due from each Carrier for both the Small Employer program and the Individual program.

B. All Small Employer and Individual Carriers

1. For Small Employer Carriers, the Office shall require quarterly and annual reports by carriers reflecting small employer enrollment and premium activities for the period reported, and shall determine due dates for filing such reports.

2. By March 1 of each year or April 1 for HMO carrier, an officer of each Small Employer Carrier and each Individual Carrier will certify to the Office its operation as a Small Employer Carrier or Individual Carrier and its status as Risk-Assuming or Reinsuring.

C. Reinsuring Carriers

1. For Small Employer Reinsurance Carriers, unless otherwise specified by the Board, the following information shall be submitted to the Administering Carrier along with Notification of Reinsurance (Article X-B):

a. Identification of the Reinsuring Carrier;

b. Name, date of birth, sex, and the Carrier identification (certificate) number of the person being reinsured;

c. Identification of the reinsured as an employee, spouse, or child;

d. Employee name (if different) and social security number;

e. Plan anniversary date;

f. Employer's name, address, zip code and SIC code;

g. Indicator of whether Reinsurance is based upon Basic or Standard Benefits;

h. Effective date of Small Employer coverage;

i. Effective date of reinsurance;

j. Date of applicable employee's employment;

k. Status code as required by the Board; and

l. Other information required by the Board.

2. For Individual Reinsuring Carriers, unless otherwise specified by the Board, the following information shall be submitted to an Administering Carrier or to the Program along with notification of Reinsurance (Article X-B):

   a. Identification of the Reinsuring Carrier;

   b. Name, date of birth, sex, and the Carrier identification (certificate) number of the person being reinsured;

   c. Identification of the reinsured as an Eligible Individual or Eligible Dependent;

   d. Eligible Individual name (if different) and social security number;

   e. Plan anniversary date;

   f. Indicator of whether Reinsurance is based upon HMO, High or Low Benefits;

   g. Effective date of coverage;

   h. Effective date of reinsurance;

   i. Status code as required by the Board; and

   j. Other information required by the Board.

3. When a change in reinsurance coverage occurs, the Reinsuring Carrier shall notify an Administering Carrier or the Program within 60 days of the change, by including:

   a. The reinsured's name and identification number

   b. For Small Employer groups, the employee's name (if different) and social security number

   c. Effective date of status change

   d. Status code for change as required by the Board

   e. Other information required by the Board

Article XVI - Financial Administration

A. Books and Records

The Program shall maintain books and records so that financial statements can be prepared to satisfy Section (11) of the Small Employer Act and Section (7) of the Individual Act. Further, these books and records shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Board and the outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when the asset is acquired or the liability is incurred and should be realized by the Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the Program shall be calculated for each Reinsuring Carrier and confirmed as deemed appropriate by the Board or when requested by the respective Carrier. These balances should be supported by a record of each individual Reinsuring Carrier's financial transactions with the Program. These records include:

    a. Net earnings/losses of for both the Individual and the Small Employer program of the Program based upon the assessments calculated in accordance with this Plan.

    b. Any adjustments to assessments as explained in this Plan.

    c. The amount of reinsurance premium due to the Program for individuals whose coverage is ceded.

    d. The amount of reimbursement due from the Program for reinsured claims paid by the Reinsuring Carrier.

    e. Adjustment to the amount due to/from the Program based upon corrections to the Reinsuring Carrier submissions.

    f. Interest charges due from the Reinsuring Carrier for late payment of amounts due to the Program.

    g. Other records required by the Board.

B. Handling and Accounting of Assets and Money

The accounts established by the Board for Eligible Individuals reinsured pursuant to the Individual Act and for Small Employers reinsured pursuant to the Small Employer Act shall be separate and segregated, and the accounts may not be comingled. However, with Board approval, funds in one pool account temporarily may be loaned to the other pool account on fair market value terms.

All bank accounts/checking accounts shall be established separately in the name of the Florida Small Employer Health Reinsurance Program and the Florida Individual Reinsurance Program, and shall be approved by the Board of Directors. Authorized check signers shall be approved by the Board.

Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board.

C. Lines of Credit

All lines of credit shall be established in the name of the Florida Health Reinsurance Program, and shall be approved by the Board of Directors. Lines of credit shall be used to meet cash shortfalls.

D. Investment Policy

All cash and other assets shall be invested pursuant to the Investment Policy developed and approved by the Board. All investment income earned shall be credited to the Program.

Article XVII - Audit Functions

A. Audits of Reinsuring Carriers and Reinsurance Claims

1. Audits prescribed by the Board shall be conducted in accordance with a uniform audit program ("Standard") for Reinsuring Carriers, as developed by the Board. This Standard shall clearly specify all items to be audited, along with the notification required. The auditor shall be required to submit a report indicating the results of the testing of each item tested. A copy of the report shall be submitted to the Board and to the Reinsuring Carrier by the auditor.

2. The Standard may include testing of representative samples of the following:

   a. Reinsurance claims submitted to the Program, in particular:

      (1) For Small Employer Reinsuring Carriers, eligibility of claimants and their Small Employers for reinsurance by the Program,

      (2) For Individual Reinsuring Carriers, evidence that reinsured individuals are Eligible Individuals,

      (3) Proper determination of reinsurance claim amounts by Reinsuring Carriers, and

      (4) Normal administration of managed care and claims adjudication procedures.

   b. Reinsurance premiums submitted to the Program, including:

      (1) Eligibility of those for whom reinsurance premium is paid, and

      (2) Proper determination of reinsurance premiums paid.

   c. Data submitted to the Program for use in the calculation of assessments for net losses.

3. Random audits of provider bills or other records may be conducted as deemed necessary by the Audit Committee, to verify the accuracy and appropriateness of reinsurance claim submissions.

4. The frequency of audits shall be determined by the Audit Committee. The cost of the audit of a Reinsuring Carrier shall be borne by that Carrier. The Board shall have the right to conduct appropriate additional audits of Reinsuring Carriers.

5. All information disclosed in the course of the audit of a Reinsuring Carrier shall be kept privileged and protected by the Carrier, the auditing firm, and the Program, to the extent permitted by law.

B. Audits of the Program

The Program shall have an annual audit of its operations conducted by an independent Certified Public Accountant approved by the Board. The Board shall file this annual audit with the Commissioner for his review.

This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program.

2. The annual fiscal report of the Program.

3. The calculation of the premium rates charged for reinsurance by the Program.

4. The calculation and collection by the Program of any First Tier assessments of Reinsuring Carriers for net losses.

5. The calculation and collection by the Program of any Second Tier assessments.

6. The reinsurance premiums due to the Program and the claim reimbursements made to Reinsuring Carriers, if applicable.

Article XVIII - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

1. Numerous factual determinations and tasks must be performed by Reinsuring Carriers relative to their participation in the Program. It is expected that all Reinsuring Carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

2. Errors related to reinsurance:

a. A Reinsuring Carrier reinsures an ineligible Small Employer/Employee/Dependent or Individual (initial placement of an ineligible person or failure to remove a person who becomes ineligible).

Reinsurance coverage for the individuals involved shall be terminated within 30 days after discovery of the error and notification to the Administering Carrier.

b. A Reinsuring Carrier reinsures an Employee/Dependent/Eligible Individual at the incorrect premium rate (failure to use correct Program rates, to make a proper Benefit Plan adjustment, and/or to apply correct rates to persons reinsured).

Reinsurance premiums for the individuals involved should be recalculated and immediate payment of additional premiums, interest, and an administrative charge established by the board must be made. Excess payments will be refunded without interest.

c. Reinsuring Carrier reinsures incorrect claim payments.

The claim will be recalculated and any amount due to the Program will be repaid immediately, with interest and an administrative charge established by the board. Adjustments of claim payments for amounts recovered by the Reinsuring Carrier under coordination of benefit, subrogation or similar provisions shall not be considered errors for which any interest or administrative charge would be due.

3. Errors related to assessments:

Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, plus any administrative charge established by the board.

4. Errors not listed:

All additional sums due to the Program as a result of errors made by Carriers shall be paid immediately, with interest and any applicable administrative charge established by the board.

5. Gross negligence and intentional misconduct:

If the Board determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Reinsuring Carrier evidences gross negligence or intentional misconduct, the Board may, after notice, terminate some or all current reinsurance for the Carrier, and/or suspend the right of the Carrier to use the reinsurance mechanism for an appropriate period of time. Within 30 days of notice of termination, the Reinsuring Carrier may request a hearing with the Board.

B. Interest and Administrative Charges

All interest payments required under this Article shall be calculated at 1.5% per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. All or some of the

administrative charge and/or interest charge may be waived by the Board. Errors reported by Reinsuring Carriers within 90 days of their occurrence shall not be subject to interest or administrative charge.

C. Limitation on Premium Refund

All premium refunds due under this Article shall be limited to a period of 3 months from the date the error was corrected unless otherwise agreed to by the Board.

D. Appeal of Disputes

An Administrating Carrier, if any, will act on behalf of the Board in the attempt to resolve disputes between a Reinsuring Carrier and the Program; however, Carriers may request permission to appear before the Board at any time in connection with a dispute with the Program.

A dispute between a Carrier and the Program involving the calculation or amount of assessments may be appealed to the Office. The appeal must be received by the Office within 45 days of the billing date and may be made only after the assessment has been paid.

A dispute between a Carrier and the Program, involving termination of reinsurance as described in Section A.5 of this Article, may be appealed to the Office. The appeal must be received by the Office within 30 days of the date the Board notifies the Carrier of its decision after hearing.

Article XIX - Indemnification

A. Neither participation in the Program, the establishment of rates, forms or procedures, nor any other joint or collective action required by the Acts shall be the basis of any legal action, criminal or civil liability, or penalty against the Program or any of the Reinsuring Carriers.

B. The Board is not liable for any obligation of the Plan. There is no liability on the part of any member or employee of the Board, or the Office, and no cause of action of any nature may arise against them for any action taken or omission made by them in the performance of their powers and duties under this Act, unless the action or omission constitutes willful or wanton misconduct.

C. In addition to the provisions in this Article, the Program shall adopt additional procedures for indemnifying the Board members and any officers or employees it deems appropriate including but not limited to the purchase of officers and directors coverage for Board Members and the Executive Director.

D. The Program shall indemnify each member of the Board, each member of any committee or any subcommittee of the Board, the Executive Director and the estate, executor, administrator, heirs, legatees and devisees of any such person (such persons and entities being herein called "Indemnified Parties") against judgments, including interest, fines, amounts paid or agreed upon in settlement, reasonable costs and expenses, including attorneys' fees, and any other liability that may be incurred as a result of any claim, action, suit or proceeding, whether civil, criminal, administrative or otherwise, prosecuted or threatened to be prosecuted (collectively, the "Legal

Cost"), for or on account of any act performed or omitted or obligation entered into, if done or omitted in good faith without intent to defraud and within what the Indemnified Party reasonably believed to be the scope of the Indemnified Party's employment and authority and for a purpose which the Indemnified Party reasonably believed to be in the best interest of and in connection with the administration, management, conduct or affairs of the Program or the Board, and with respect to any criminal actions or proceedings, in addition had no reasonable cause to believe that the Indemnified Party's conduct was unlawful. Provided, however, that if any such claim, action, suit or proceeding is compromised or settled, it must be done so with the prior and express approval of the Board.

E. Such indemnification shall not depend upon whether or not the Indemnified Party is a member of the Board, or any committee or subcommittee thereof, at the time such claim, action, suit or proceeding is begun, prosecuted or threatened nor on whether or not the liability to be indemnified was incurred or the act or omission occurred prior to the adoption of this Article XVIII.

F. The right of indemnification hereunder shall not be exclusive of other rights the Indemnified Party may have as a matter of law or otherwise.

G. In each instance in which a question of indemnification hereunder arises, including, without limitation, those instances in which the Board, or any members of the Board, or any other Indemnified Party, are seeking indemnification hereunder as a result of the same occurrence, determination in the first instance of the right to indemnification hereunder, and of the time, manner and amount of payment thereof, shall be made by the Board. Nothing in this paragraph is intended to make an adverse determination finally binding upon the Indemnified Party, or to preclude any Indemnified Party to enforce a right of indemnification under this Article.

H. The indemnification provided for in this Article shall be deemed to be an administrative expense of the Board to which all the carriers shall contribute as described in Article XIII paragraph I. of the Plan.

I. In addition to, and not in derogation of any rights to indemnification hereunder, the Board shall be fully authorized to advance Legal Costs to every Indemnified Party at such times, in such amounts and in such manner as the Board, in its discretion, shall determine; provided, however, that Legal Costs shall not be advanced if the Board determines that the facts then known to it preclude the Indemnified Party from indemnification under this Article.

Article XX - Amendment, Termination

A. Amendments

Amendments to this Plan may be suggested by any Reinsuring Carrier or member of the board and may be made by majority vote of the Board at any time, subject to the approval of the Commissioner. Amendments submitted to the Commissioner become effective upon written approval of the Office.

B. Termination

The Program shall continue in existence subject to termination in accordance with the requirements of a law or laws of the State of Florida or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the Program, the Program shall terminate and conclude its affairs. Any funds or assets held by the Program following the payment of all claims and expenses of the Program shall be distributed to the Small Employer Reinsuring Carriers and Individual Reinsuring Carriers at that time in accordance with the then-existing assessment formula.

Attachment F

Balance Sheet
November 30, 2023
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Assets				
Cash Operating	57,402.63	14,016.84		71,419.47
Cash Depository	11,494.34			11,494.34
Cash Special Purpose	680.96			680.96
Prepaid Expenses	-	-		-
Due from Indiv Pool	(2,825.76)		2,825.76	-
Assessments Receivable	-	-		-
Total Assets	66,752.17	14,016.84	2,825.76	83,594.77
Liabilities				
Federal Income Tax Payable				-
Due to Small Employer Plan		(2,825.76)	2,825.76	-
Accrued Audit Fees	13,129.13	6,708.26		19,837.39
Account Payable - Postage	-	-		
Account Payable - Line1 Comm	-	-		
Total Liabilities	13,129.13	3,882.50	2,825.76	19,837.39
Net Assets	**53,623.04**	**10,134.34**	**-**	**63,757.38**
Total Liabilities and Net Assets	66,752.17	14,016.84	2,825.76	83,594.77

Income Statement
For the Month Ended November 30, 2023
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Revenues				
Interest Income	16.71	19.23		35.94
Expense Write-off	-	-		-
Approved Assessments	-	-		-
Expenses				
Contract Services	45,650.00	9,350.00		55,000.00
Professional Fees	6,579.13	3,458.26		10,037.39
Meetings	-	-		-
Storage Fees	45.19	9.26		54.45
Adobe Acrobat	149.31	30.58		179.89
PO Box	580.80	118.96		699.76
Postage	-	-		-
Document Destruction	226.60	46.41		
Total Expenses	53,231.04	13,013.46		65,971.49
Change in Net Assets	($53,231.04)	($13,013.46)		($66,244.50)
Net Assets, January 1, 2023	110,887.21	19,131.32		130,018.53
Net Assets, October 31, 2023	**57,656.17**	**6,117.86**	**-**	**63,774.03**

Attachment G

Florida Health Insurance Advisory Board
Proposed Budget
January 1, 2024 – December 31, 2024
[12 Months]

Expense Category	2023 Actual*	Proposed Budget
Contract Management	**$60,000**	**$60,000**
Legal Services	**$0**	**$5,000**
Meeting Expenses	**$0**	**$100**
Miscellaneous Expenses	**$0**	**$100**
P.O. Box	**$372**	**$400**
Postage/Delivery	**$19**	**$50**
Shredding Services	**$273**	**$0**
Storage Services	**$55**	**$0**
Supplies/Printing	**$15**	**$50**
Adobe Writer Subscription	**$200**	**$240**
Travel	**$0**	**$0**
Telephone / Conference Call [4 calls]	**$400**	**$600**
Website Services	**$0**	**$2,500**
Total Expenses to be Apportioned		**$66,540**
Small Group Portion (83%)		**$55,228**
Individual Portion (17%)		**$11,312**

Funding (Assessment) Need

	Small Group Plan	Individual Plan
Expected Balance 12/31/2023	$55,526	$12,445
2024 Audit Costs Estimated**	($14,000)	($7,600)
2024 Allocated Expenses	($55,228)	($11,312)
Three-Month Reserve	($13,695)	($2,805)
Total Calculated Assessment	$27,397	$9,272
Recommended Assessment	**$35,000**	**$15,000**

**At the time of December Board meeting, CY 2023 is not over. These include estimated amounts for the remainder of 2023.*

***Estimates cost for 2023 Audit, and accumulated liability for 2024 Audit*

Attachment H

Proposal # 1: Deductible Health Credit Transfer

Louisa McQueeney – Florida Voices for Health

With the continual rise in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year creates financial hardship. The deductibles for 2024 could end up being as high as $9,450 for an individual and $18,900 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all.

When consumers change health insurance plans outside of the Open Enrollment period, because of an employer changing plans outside of annual renewal, or a change of employer, or a change in geographic area, or loss of employer coverage and purchase individual coverage, annual deductibles start all over again even if a consumer has met part or all the accumulators out of their own pocket. This is even more egregious when consumers stay with the same carrier with the expectation already incurred accumulators will be recognized, only to find out that they will not.

□ Recommendation: Expand statute 627.666 to include individual on- and off-exchange policy holders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policy holder to the prior insurer. The Credit Transfer should be for the entire amount paid by the consumer without limitations such as a period of 90 days preceding the effective date of the succeeding insurer's plan or recognition of the expenses actually incurred under the terms of the succeeding insurer's plan and subject to a similar deductible provision.

Proposal # 2: Provide Health Care Consumers with One Free Copy of their Own Medical Records

Louisa McQueeney – Florida Voices for Health

Patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). However, the same law allows providers to charge fees for providing the requested copies. Many record requests are not honored in a timely fashion if honored at all and can be at great expense to the consumer. Obtaining one's own medical records is especially important when disputes arise with insurance companies, resulting in denial of claims, leaving patients in precarious financial positions. Having a patient see and review their medical records and related provider charges billed to the insurer just makes common sense. It would bring down improper billing and potential fraud, which in turn should lead to lower health insurance costs to both plan sponsors and individuals.

□ *Recommendation: Provide consumers with one free copy of their medical record provided to consumer by mail or electronic mail, within 90 days of discharge or at the time of provider payment request for services provided, whichever comes sooner.*

Proposal # 3: Protect Consumers from Prescription Drug Formulary Changes During a Policy Year

Louisa McQueeney – Florida Voices for Health

Drug pricing remains at the forefront of consumer complaints when accessing health coverage. Consumers often pick a health insurance plan based on the prescription drugs covered and the cost tiers they are classified in.

Consumers enter a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period based on the contract they were presented. Health insurance plans negotiate drug prices with the pharmaceutical companies on behalf of consumers, without any involvement or say of consumers.

Insurance carriers then present health plans including drug formularies and premium rates to the Office of Insurance Regulation for approval. The consumer's input is not part of the process, but the consumer is expected to pick up the extra cost in the end or go without the prescription(s) they contracted for.

In recent years insurance carriers have been making changes to their drug formularies during the policy period. Insurers routinely reclassify drugs to more access restrictive drug tiers, increase the consumer's co-payment, co-insurance, or deductible, and reclassify drugs to higher cost sharing tiers. There are also instances of certain drugs being dropped from coverage altogether. Consumers are then informed by mail that they will be financially responsible for the entire cost of the drug in the middle of the policy year.

□ *Recommendation: Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier from expanding the formulary and lowering prices throughout the policy year. This would exclude the formulary for Florida Medicaid which is covered under section 409.91195, Florida Statutes.*

Proposal # 4: Cap the Cost of Insulin at $35 a Month

Louisa McQueeney – Florida Voices for Health

The Inflation Reduction Act of 2022 has reduced the cost of insulin to no more than $35 per month for people on Medicare. This includes insulin pumps. However, the law doesn't extend to individual and group health plans. Although some pharmaceutical companies did lower their prices for insulin, the cost of insulin, which has been around for 100 years, is 10 times higher in the US than any other developed country and creates an enormous financial burden on Floridians who cannot survive without. We have all heard heartbreaking stories. While there is no high cost of development to insulin and innovation is limited, there is also no "free" market where market forces would drive down the cost to consumers. This lack of "free" market allows for price increases at will for this lifesaving medicine. Putting a cap on the price of insulin will save money through less hospital admissions for high blood sugar emergencies and less health complications resulting in disability. 22 States and the District of Columbia have enacted insulin price caps legislation. Putting a cap on the cost of insulin would drive down the cost of healthcare for all Floridians

□ *Recommendation: Require individual & group health insurance policies to cap insured's monthly cost-sharing obligation for covered prescription insulin drugs at $35 starting with 2024 plans; require health maintenance contracts to cap subscriber's monthly cost-sharing obligation for covered prescription insulin drugs at $35 starting with 2024 plans.*

Proposal # 5: Prohibit Balance Billing for Ground Emergency Medical Transportation

Louisa McQueeney – Florida Voices for Health

The No Surprises Act of 2019 addressed many balance billing or "surprise" billing issues for consumers. However, it didn't address the cost of ground emergency medical transportation. Consumers in a life-threatening accident or major medical emergency in need of ground emergency transportation to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but this coverage gap can leave consumers with surprise high medical bills for the service.

□ *Recommendation: Apply the balance bill rules under HB221, signed into law by Governor Scott, to include ground emergency transportation.*

Proposal # 6: Include Applied Behavioral Analysis as a Covered Benefit in all Insurance Plans

Louisa McQueeney – Florida Voices for Health

As required by federal law Florida's Medicaid program covers medically necessary Applied Behavioral Analysis (ABA) services to correct, or ameliorate a defect, a condition, or a physical or mental illness for eligible recipients under the age of twenty-one.

These services are extremely important for recipients with developmental disabilities. In the health insurance market these services are required under statute section 627.6686, and applicable to a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. However, these services are not required to be included in any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

Once a recipient loses Medicaid eligibility, they lose coverage for these important services. Neither KidCare program policies nor exchange and off exchange policies cover ABA services, placing an undue financial burden on families already dealing with very difficult circumstances. Expanding some plans off and on exchange to include coverage for ABA services could provide relief for this population.

□ *Recommendation: Require each carrier authorized to sell health insurance in Florida to include at minimum one plan in each service area to cover Applied Analysis Services as covered by Medicaid.*

Proposal # 7: Add Fetal Alcohol Spectrum Disorder (FASD) to Include to the Definition of the Term Developmental Disabilities

Louisa McQueeney – Florida Voices for Health

Harm to Florida's children from prenatal alcohol exposure (PAE) is a significant public health problem and the leading known cause of preventable developmental disabilities in the United States. Given that nearly half of pregnancies are unintended and women often don't realize they are pregnant until they are 6 weeks along or more, makes it easy to understand that women could drink alcohol while not knowing they are expecting. Many myths and misconceptions about the risk of alcohol use during pregnancy remain despite nearly 50 years of research.

Recent studies show an alarming prevalence of up to 1 in 20 first graders in the United States meeting criteria for Fetal Alcohol Spectrum Disorders (FASD) classification. PAE is especially harmful to the developing brain and could impact all facets of a child's life. Research also shows alcohol causes far greater harm to the brain than other drugs, yet recognition of the disability -- with appropriate FASD-informed supports and services -- can prevent secondary disabilities. Without these supports and services, many young adults with FASD may end up incarcerated, homeless, vulnerable to substance abuse, unemployed, and reduced access to health care.

Among medical and behavioral health professionals, inconsistent use or limited knowledge of diagnostic criteria and clinical guidelines result in many (if not most) children and adults living with FASD going undiagnosed or misdiagnosed. Families struggling with children with FASD, many of them adopted or fostered, cannot find systems of care that are familiar with or equipped to diagnose and address FASD-related disabilities. Although there is no cure for individuals impacted by FASD, research shows intervention services and support, including social, environmental, and educational strategies can prevent subsequent trauma to the individual, their caregivers, and society.

□ *Recommendation: Include Fetal Alcohol Spectrum Disorder to the list of definitions of the term developmental disabilities in statute 627.6686.*

Proposal # 8: Apply Payments by, or on Behalf of, a Beneficiary to Count Toward the Out-of-Pocket Cost Sharing Calculations

Louisa McQueeney – Florida Voices for Health

Patients, even those with health insurance, are having difficulty affording their medications because of steadily rising out-of-pocket costs. To help cover the patients' copays and co-insurance, some drug manufacturers, charitable assistance foundations, and other third parties offer copay assistance programs to help patients with serious chronic conditions afford their specialty drugs. Most patients, who use copay assistance require highly specialized, life-saving medications to treat hemophilia, MS, HIV, cancer, and other rare and chronic diseases for which, in many cases, no generics or lower-cost drugs are available.

In recent years, insurance companies and pharmacy benefit manager (PBMs) have implemented so-called "copay accumulator adjustment programs" where none of these copay assistance payments made on behalf of the patient count towards their deductible and annual maximum out of pocket costs. In addition, most insurance plans make it very difficult for a patient to find out if they have an accumulator program, using very vague language, if any at all in plan policy documents.

The financial assistance that patients receive is a specified amount per year based on the cost of the prescription. Patients often discover mid plan year that the copay assistance limit has been reached and they must pay the entire cost of the prescription drug because none of the third-party payments were counted towards their out-of-pocket costs – defeating the purpose of the copay assistance. Research has shown that many patients will abandon their medication at the pharmacy or ration doses when they must pay more than $75 to $225 out of pocket, foregoing life-saving medication. With copay accumulator programs, insurers and PBMs are collecting the financial assistance, the money, intended for the patient while requiring the patient to pay the deductible again, making it harder for consumers get their medications and other health care.

As of June 2023, 19 states have passed legislation prohibiting copay accumulator policies: Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia,

Illinois, Kentucky, Louisiana, Maine, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, Virginia, Washington, and West Virginia.
Earlier this year, Governor DeSantis signed SB 1550 into law, requiring more transparency and accountability from PBM's. Unfortunately, a ban on copay accumulators, the harmful and deceitful practices of insurers and PBMs towards many vulnerable Floridians, who are having to make choices between getting their medications or buying food, was once again not included.

□ *Recommendation: Require each health insurer, issuing, delivering, or renewing a policy in Florida, which provides prescription drug coverage, administered by the insurer or pharmacy benefit manager, to count any amount paid by the insured or paid on his or her behalf through a third party (including but not limited to manufacturer or provider cost share assistance payments such as manufacturer cost share assistance) toward the policyholder's total contribution to any deductible or out-of-pocket requirement. Insurers must include in policy documents, such as the summary of benefits, and on websites that these payments will be applied to the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.*

In the absence of legislation prohibiting copay accumulator policies, each health insurer, issuing, delivering, or renewing a policy in Florida, which provides prescription drug coverage, administered by the insurer or PBM must clearly disclose the copay accumulator in the summary of benefits, in policy documents and on websites, made available to consumers prior to enrollment in a policy and that payments paid on his or her behalf will not count towards the policyholder's out-of-pocket costs maximum, deductible, or copayment responsibility. In addition, payments made on behalf of the policy holder must appear on the explanation of benefits (EOB) as a payment the insurer will not apply towards the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.