Patient Protection & Affordable Care Act (PPACA) Overview

Senate Select Committee on PPACA

January 22, 2013

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Office of Insurance Regulation (Office) Objectives - PPACA

- Reduce uncertainty to help maintain a stable market
- Allow companies to expedite product approval
- Promote off-exchange competition
- Maintain consumer protection / transparency

Life & Health Product Review

Form Review - Florida is a Prior Approval State:
For all policy forms (large group, small group and individual)

- Determine compliance with Florida Statutes and Rules (e.g., policy contracts, enrollment forms, schedule of benefits)

Rate Review - Florida is a Prior Approval State:
For small group and individual policies

- Actuarial reviews of rate filings to ensure compliance with Florida Statutes and Rules

Examples of Rating Factors:
Age
Gender
Smoking status
Geographic location

Examples of Analysis Factors:
Historical loss experience
Medical trend
Insurance trend
Risk changes

Major Challenges

- Conflicts between federal/state law
- Substance of Office form & rate reviews
- Potential resource issues

Conflicts with Florida Law

Federal law vs. Florida law

Rating Examples:

Age rate banding
Gender equality in rating

Policy Form Examples:

Rescission language
Dependents to age 30

(Supplemental: Office of Insurance Regulation Preliminary Review PPACA October 12, 2012)

Current Form Review Options

Approve

Form complies with all PPACA laws and Florida laws

Form complies with only Florida laws

Disapprove

Form complies with all PPACA laws, but not Florida laws

Current Regulatory Environment

Rate Review:

- Premiums are reasonable in relation to benefits
- Rates cannot be excessive, inadequate or unfairly discriminatory

Outcome:

Disapprove based on conflicts with age/gender rating

Form Review Logistical Issues

[If Office were to Proceed with Reviews]

Influx of Filings:

- Hiring additional full-time employees (not feasible)
- Outsourcing (possible, but expensive)

Short Time-Line for Exchange Products:

- March 28, 2013 – Companies may file products with Health & Human Services (HHS)
- May 1, 2013 – Companies submission deadline for products to be filed with HHS
- July 31, 2013 – HHS deadline for products to be approved

Options

1. Expand Florida law to incorporate PPACA
    - Revise current statutes
2. Retain Florida law / Rely on federal preemption
3. Short-term use and file informational only rate & form exemption
    - Must exempt rates from substantive requirements of Florida law & rules
    - Administrative options

Rate Review Logistical Issues

[If Office were to Proceed with Reviews]

- New products without historical experience
  - New risk population
  - Uninsured
  - Pre-existing conditions
- Pent-up demand
- Federal risk redistribution programs

Advantages of Short-Term Rate & Form Exemption (Information Only Filings)

- Speed-to-Market (more products)
- Regulatory certainty
- Transparency (informational filings in I-File)
- Experience for future reviews
- Florida laws still apply for consumer protections & policy forms

Other Challenges: Filing Requirements

- Unique form & rate filing situation
  - 49 states use the System for Electronic Rate & Form Filing (SERFF) via the National Association of Insurance Commissioners (NAIC)
  - Florida uses the I-File System
- Public records issues
- State filing and Health Information Oversight System (HIOS) filings
- Potential duplicate filing issue

Question & Answer Participants

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Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
2010 (prior to 09/23/2010)			
"Grandfathered" Insurance Products – **Effective: Date of enactment -- (March 23, 2010)**	All coverage in place on the date of enactment. PPACA Sec. 1251	**Note/NAIC** • Updated by HHS: The update allows fully-insured group health plans to retain their grandfathered status if they replace existing coverage with a new policy, so long as the terms of the new policy do not violate any of the tests which would cause an existing plan to lose grandfathered status.	**FL Insurance Code** • Does not recognize "grandfathered" insurance plans for purposes of review or regulation ***Florida Health Plans*** • *Guaranteed Renewability requires treating all members within a plan the same on renewal--creates a conflict* • *Without a statutory change, GF members will not be able to be treated differently from NGF and thus will lose their GF status on renewal; therefore, the Guaranteed Renewability statute should be amended to allow a distinction between GF and NGF members.* • *The ACA mandates apply to GF and NGF plans differently upon renewal in 2014.*
Web portal to identify affordable coverage options **Effective: 07/01/10** **Secretary of HHS, in consultation with the states**	Individual Small Group Plans PPACA Sec. 1103	**Note/NAIC** • Carriers and state regulators required to file information with HHS to facilitate consumer shopping for health insurance products by state of residence	**FL Insurance Code** • No FL Insurance Code requirement to provide OIR with information filed by carriers for healthcare.gov website display. **Note/FL OIR** ***Health Insurance Oversight System (HIOS):*** • Generally, it is unclear if FL OIR has unrestricted access to all information filed through the HIOS system by carriers authorized to transact insurance in FL – which includes plan details, rates, etc. • Confidentiality is preserved at federal level. An MOU between NAIC and HHS for data access from the HIOS site, does not extend to the States. • In Florida, should an MOU be proposed, there may be additional consideration needed with respect to the application of the State's open records laws and resulting public records requests.
Health insurance consumer assistance offices and ombudsmen Effective: Date of	*PPACA Sec. 1002 /PHSA 2793*	*The Secretary of HHS shall provide $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs.*	***FL Insurance Code*** *Not within the scope of those provisions of the Insurance Code administered by the OIR.*

Text identified as "Florida Health Plans" are carrier - comments informally communicated to the OIR – and are not an official position of the Florida Association of Health Plans.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
2010 (prior to 09/23/2010)			
enactment			
Temporary high risk pool program **Effective: 90 days after enactment** ***Floridians eligible for PCIP effective August 1, 2010*** **Secretary of HHS**	PPACA Sec. 1101	HHS has established a temporary high risk health insurance pool program. $5 billion allocated to fund pools through 2013. **Florida** • Declined to operate state-based high risk pool. Florida residents are eligible for Federal Preexisting Condition Insurance Program (PCIP) FL PCIP census as of August 31, 2012: Enrollment: 8,145 *Note: As of June 30, 2012* • **Claims paid** for FL PCIP Members: **$107,841,608** -- *Numbers do not include administrative expense associated with FL enrollees; does not include administrative expense of CCIIO.*	**FL Insurance Code** • FL current high risk pool closed since 1992 (FCHA –s. 627.648-s. 627.6498) • FL Health Insurance Plan (FHP) designed in 2004 to reestablish a high risk pool (s. 627.64872) was never made operational by the Legislature *FL Question for CCIIO?* What is status of **persons currently covered by FCHA plan**? i.e., is FHCA plan considered a "grandfathered" plan? **Note/FL OIR** The Federal PCIP program is designed to sunset by 2015 and those individuals moved back into individual market where individuals cannot be excluded for coverage because of a pre-existing condition – i.e., will become part of "pool" of all risks in the FL individual market.

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September 23, 2010			
Preexisting condition exclusions **Effective for Plan years on or after September 23, 2010**	All plans except grandfathered individual market plans PPACA Sec. 1201 & 10103(e) /PHSA 2704	A plan may not impose any preexisting condition exclusions for **children under age 1**9. *FL Note: Currently there is no child-only coverage (private or public) for age birth to one, for a family with incomes over 185% of the Federal Poverty Level (FPL)*	**FL Insurance Code** • s. 627.6045, 627.6561, and 641.31(16) • Carriers offering "child only" health policies ceased new writing in 2010; • FL law will need to be amended to comply with ACA requirements
Rescissions **Effective for Plan years on or after September 23, 2010**	All plans PPACA Sec. 1001 /PHSA 2712	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Notification must be made to policyholders prior to cancellation (30 days).	**FL Insurance Code** Generally, s. 626.9541(1)(g)3. -- unfair discrimination *Other statutes* • s.627.607 allows rescission up to 2 years. After 2 years only for fraud • FL law will need to be amended to comply with ACA requirements, including notice requirements o *Example: for individual policy* - s. 627.6043 (45/10 day notice for non-payment of premium) ***Florida Health Plans*** *Direct Conflict between ACA and FL laws* • *FL law currently allows rescissions up to 2 years after issuance of the policies and after 2 years for fraud* • *627.607 Time limit on certain defenses*
Annual Limits **Effective for Plan years beginning on or after September 23, 2010**	Annual limits: All plans except grandfathered individual market plans *Note: does not*	No annual limits for essential health benefits. • Note: Annual limits on essential benefits are limited to$2 million for plan years beginning 9/23/2012-12/31/2013 Note/NAIC • *Plans may still impose annual and*	**FL Insurance Code** Current law/rules are silent regarding most annual limits. However • There are some annual limits set for some mandated benefits: o Autism -- $36,000 per year (s. 627.6686 and s.641.31098) o Home health services, no less than $1,000 per year (s. 627.6617):

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September 23, 2010			
	apply to health flexible spending arrangements PPACA Sec. 1001/ PHSA 2711	*lifetime limits on specific covered benefits that are not essential benefits, which have not yet been defined in regulation.* • *In the interim, "the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term."*	o Substance abuse – maximum of 44 outpatient visits at a max of $35/per outpatient visit (s.627.669) **Note/FL OIR** • Because this requirement affects plans inside and outside the exchange ... How will "actuarial equivalency" be treated for plans offered outside the exchange?
Lifetime Limits **Effective for Plan years beginning on or after September 23, 2010**	Lifetime limits: All plans *Note: does not apply to health flexible spending arrangements* PPACA Sec. 1001/ PHSA 2711	• Plans may not establish lifetime limits *on the dollar value of essential benefits.* • Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS (Waiver program for carriers, employers to seek waivers for "mini-med" plans was operational in 2010)	**FL Insurance Code** Current law/rules are silent regarding allowable annual lifetime dollar limits – *except for autism benefit* – • annual dollar limit in current FL law for autism benefits ($200,000 lifetime) may be pre-empted if autism treatments are considered an essential medical/mental health benefit • This $200,000 limit is indexed to the medical component of the consumer price index • Current law does not define essential benefits ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements*
Coverage of preventive health services **Effective for Plan years beginning on or after September 23, 2010** **Secretary of HHS**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2713	Plans must provide coverage without cost-sharing for specified preventive services, screenings, immunizations. ***Note/NAIC:*** • Plans that have a network of providers may impose cost sharing for preventive items and services delivered by out-of-network providers. • Plans may use reasonable medical management techniques for coverage of preventive items and services to	**FL Insurance Code** Current law/rules are generally silent regarding what constitutes a "preventive" service or limits/prohibitions on cost-sharing for such benefits However, there are certain provisions within the Insurance Code that will need amendment to comply with PPACA **Autism** -- behavior assessments (627.6686/641.31098) Child has to be diagnosed as having a developmental disability at 8 years of age or younger • HHS Regulation: up to age 17 **Child Health Supervision** s. 627.6416, 627.6579; 641.31(30).

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September 23, 2010			
As of August 1, 2012 – List of Preventive Services exempt from cost-sharing requirements http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html		determine the frequency, timing, method, treatment or setting of services to the extent that they are not specified in the relevant recommendation or guideline. • If a preventive service is billed separately from an office visit, the plan may impose cost sharing on the office visit. If it is not billed separately from the office visit, then the plan may not impose cost-sharing on the visit if the primary purpose of the visit is to receive the preventive item or service. • A plan may impose cost-sharing for a treatment not described in the regulations, even if that treatment results from an item or service that is a covered preventive service.	(Immunizations, hearing, vision testing, etc.) in compliance with standards of *American Academy of Pediatrics* – • HHS: Preventive care and services ...supported by the *Health Resources and Services Administration (HERSA*) Note/OIR: Benefit is not subject to deductible requirements—s. 627.6416((1) **Newborn Hearing Screening** 627.6416, 627.6579, 641.31 (30), et.al. **Mammograms** –baseline, frequency by age groups (s.627.6418, 627.6613, 641.31095) • HHS: frequency standards may not be as specific – i.e., every 1-2 years for women aged 40 and older (FL Law: once every year beginning age 50) *"**Well-woman**"* – s.627.6472(18), 627.662(9), 641.51(11), et.al. OBGYN Annual Visit – • HHS has list of specific preventive services **Osteoporosis** Diagnosis—627.6409, 627.6691, 641.31(27) • HHS requires screening for women only after age 60 and depending on risk ***Florida Health Plans*** • All NGF plans must cover preventive services at no cost share New statutory authority needed to enforce new ACA requirements • Need statutory authority to enforce new ACA requirement • Amend current mandates to apply to GF plans only (e.g., mammograms, osteoporosis, OB/GYN visit.
Extension of adult dependent coverage **Secretary of HHS** **Effective for Plan years beginning on or after September 23,**	All plans PPACA Sec. 1001 HR 4872 §2301 /PHSA 2714	Plans that provide dependent coverage must make coverage available to adult children up to age 26. • Carriers are not required to cover children of adult dependents. • For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.	**FL Insurance Code** • s.627.6562(1): Requires coverage up to the end of the calendar year in which the child reaches age 25 but with restrictions (must be unmarried without dependents of his/her own and must be resident or full-or part-time student, and is not eligible for other coverage; • At ss.627.602(c), 627.6562, 641.31(41): Under these same restrictions, coverage must be *offered* up to age 30. **Note/FL OIR**

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September 23, 2010			
2010		*Note/NAIC* Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency, residency; student status, employment, eligibility for other coverage, marital status or any combination of these.	• For up to age 26, federal law is less restrictive than FL law and thus may preempt FL law restrictions applicable to dependents under age 26. • FL would appear able to enforce its restrictions on the offer of coverage from age 26-30. ***Florida Health Plans*** • *Direct Conflict between ACA and FL laws.* *See 627.6562 Dependent coverage* • *Need to remove criteria for dependent coverage such as support, residency and student status up to age 26 from current statute.* • *Criteria for ages 26-30 may continue to apply.*
Provision of additional information **Effective for Plan years beginning on or after September 23, 2010**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2715A	All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage • Other information as determined appropriate by the Secretary	**FL Insurance Code** There is no provision in FL Insurance Code to require disclosure of all of these items in a "single location" posting and/or disclosure document.
Prohibition on discrimination based on salary ***Effective for Plan years beginning on or***	*Fully insured non-grandfathered group health plans* *PPACA Sec. 1001*	*Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans.* *The Secretary of HHS will develop rules.*	***FL Insurance Code*** *As noted by NAIC, until guidance is issued, OIR could not assess the need to amend current statutes to incorporate any requirements made for fully-insured plans not governed by ERISA.*

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September 23, 2010			
after September 23, 2010 ***Applicability suspended until guidance is issued.***	*/PHSA 2716*	*Status: IRS seeking comments, but suspends application of this provision until after regulations/guidance has been issued. (NAIC, 11/2011)*	
Appeals process – Internal and External Review Standards **Effective for Plan years beginning on or after September 23, 2010** **Secretaries of Labor and HHS**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Model Act or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.	**FL Insurance Code** In 2012, in SB 730, by amendment to s. 627.602, policies issued for individual health insurance are required to comply with 29 CFR s. 2560.503-1 relating to internal grievances. Similarly, at newly created s. 627.6513, the provisions of 29 CFR s. 2560.503-1 are made applicable to all group health insurance policies. **Note/FL OIR** • ***29 CFR s. 2560.503-1 is entitled "Claims Procedure***" and governs how claims for adverse determinations are to be processed. • However, it is 29 CFR s. **2590.715-2719, entitled "Internal claims and appeals and external review processes"** that actually sets forth the standards for creation/implementation of both internal and external review programs. • FL law delegates standards for compliance to specified federal regulation for internal review. – but does not grant rule-making authority to the OIR to implement the standards of the federal regulation. • SB 730 does permit the OIR to promulgate rules that adopt the NAIC Model for external Review for HMOs (only). o OIR is currently drafting the HMO rule to adopt NAIC Model Act and Regulations for External Review. ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements.*
Patient Protections **Emergency**	All non-grandfathered plans	**Emergency Services** • If a plan provides coverage for emergency services, the plan must do	**FL Insurance Code** • FL law makes emergency services coverage subject to similar standards at s. 641.513(3) and 641.31(2) governing HMOs.

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September 23, 2010			
Services **Effective for Plan years beginning on or after September 23, 2010**	PPACA Sec. 1001 /PHSA 2719A	so without prior authorization, regardless of whether the provider is a participating provider. • Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.	• FL law does NOT make this provision applicable to individual, large group, or small group indemnity plans. ***Florida Health Plans*** 641.19(6) and (9) Definitions • Direct Conflict between ACA and FL laws • The reimbursement for non-participating providers of emergency services conflicts with payment rules under FL law. • Statute should be revised to apply to GF only and section applicable to NGF should be included. • Definitions for Emergency Medical Condition and Emergency Services should be revised to align with ACA definitions for NGF plans.
Patient Protections **Primary Care Provider** **Access to OB-GYN services** **Effective for Plan years beginning on or after September 23, 2010**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719A	**Primary Care Provider** A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. **Access to OB-GYN services** A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.	**FL Insurance Code** *Primary Care Providers* • FL law makes a requirement for primary care physicians for HMOs at 641.19(13)(e). • FL law does NOT make this provision applicable to individual, large group, or small group indemnity plans. *Access to OB-GYN Services* • s. 641.19(13)(e): Requires HMOs, small group HMOs to permit a female subscriber to select an OB-GYN as her primary care provider – thus no referral authorization would be required. • FL law does NOT make this provision applicable to individual, large group, or small group street indemnity plans. ***Florida Health Plans*** Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements • New statutory authority needed to enforce new ACA requirements.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective 01/01/2011			
Medical Loss Ratios **Effective: 01/01/11**	All fully insured plans, including grandfathered plans PPACA Sec. 1001 /PHSA 2718	• Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. • Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. • All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups.	**FL Insurance Code** There is no current statutory authority to implement new MLR requirements or to govern insurer compliance with required notices related to rebate determinations.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Rate increase in excess of 10% filed on or after July 1, 2010			
Rate Review **Effective: 2010 plan year** **A rate increase in excess of 10% for increases filed on or after July 1, 2011** **The Secretary in conjunction with the states.**	All non-grandfathered fully-insured plans PPACA Sec. 1003 /PHSA 2794	Rates subject to review. A rate increase in excess of 10% for increases filed on or after July 1, 2011 If a state reviews the increase, HHS will adopt the state's determination and will post the state's final determination on its website. If an insurer elects not to implement an unreasonable increase or to implement a lower increase, it must notify the state and HHS of that fact. If the issuer implements an unreasonable increase, it must submit a final justification to HHS and prominently post the information on the company web site for at least 3 years.	**FL Insurance Code** • FL has been determined by HHS to have an effective rate review program for individual and small group policies. • HHS has determined FL does NOT have an effective rate review program for association policies (rates for out of state associations are not subject to OIR rate approval (s. 627.410(1)); • FL does NOT approve rates for large group policies with 51 or more persons per s. 627.410(6)(a). **Note/FL OIR** • HHS determination of an effective rate review system includes the requirement for a state to maintain on its website a user-friendly program to permit consumer review of proposed rate changes and to file comments prior to final state action. • The OIR has implemented access to rate filings, and continues to make information more complete and more user friendly – although additional resources for technology upgrades would facilitate these changes.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
January 1, 2012			
Accountable Care Organizations (ACOs) **(Effective January 1, 2012 for Medicare only)**		The new law provides incentives for physicians to join together to form "Accountable Care Organizations." ACOs are authorized to participate as health plans offering coverage through an Insurance Exchange.	**FL Insurance Code** • Currently, there is no FL insurance law that would apply to this risk-bearing entity. **Note/FL OIR** • ACOs are authorized for participation in the State's Medicaid Managed Care statutes (Medicaid Reform, 2011).

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Within two (2) years – September 23, 2012.			
Uniform explanation of coverage documents and standardized definitions ***In consultation with NAIC***	All plans PPACA Sec. 1001 /PHSA 2715	The Secretary must develop standards for a summary of benefits and coverage (SBC) explanation to be provided to all potential policyholders and enrollees. The SBC must be made available in a culturally and linguistically appropriate manner.	**FL Insurance Code** At s. 641.31(1) and (4) HMOs are required to provide disclosures including a member handbook. At s. 624.308, 627.642, 627.643 and 69O-154.107 FAC (Individual) there are some standards for outlines of coverage. However – if HHS adopts Regulations similar to those provided by the NAIC, FL statutes and rules would need to be amended and/or created to reflect these HHS requirements.
Ensuring quality of care **Effective: 2 years after enactment** **Secretary of HHS, in consultation with experts in health care quality and stakeholders**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2717	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan improve health outcomes.	**FL Insurance Code** • There is no current statute or rule requiring submission of this kind of information to the OIR. • Current annual reporting requirements for health and accident insurance are at s. 627.9175.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective in 2013			
Administrative simplification requirements **Rules adopted by July 1, 2011 to become effective by January 1, 2013.**	PPACA Sec. 1104 /SSA 1171	Requires the Secretary to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information	**FL Insurance Code** It is unknown if requirements regarding the standards of exchange of medical information (and standardized billing) would require amendments to the Florida Insurance Code.
Co-Op Plans – Consumer Owned and Operated (Health Plans) **Effective: No later than 7/1/2013** **Secretary of HHS**	Co-Op Plans PPACA Sec. 1322	**C**onsumer **O**wned and **O**perated Health **P**lans (risk bearing) -- • The Secretary of HHS shall provide Co-Op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. • Secretary must ensure that there is sufficient funding to establish at least 1 Co-Op plan in each state. • Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. **Note/NAIC** Co-Op plans may not offer coverage in a state until the state has adopted the market reforms in Subtitles A and C of this legislation.	**FL Insurance Code** **Note/FL OIR** As outlined in PPACA , a Co-Op entity in this State, as a risk-bearing entity, would be regulated by the OIR – and preliminary review suggests a Co-Op would be determined to be a form “mutual insurance company” However, if FL has not adopted “market reforms in Subtitles A and C of PPACA, it is unclear if the HHS would recognize a Co-Op planning to operate in this State.

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Effective Plan Year 2014			
Preexisting condition exclusions **Effective: Plan years beginning 01/01/14 for all others**	All plans except grandfathered individual market plans PPACA Sec. 1201 /PHSA 2704	A plan may not impose any preexisting condition exclusions.	**FL Insurance Code** FL law currently permits waiting periods which may not be in compliance with HHS final rules on preexisting condition requirements for 2014. ***Florida Health Plans*** ***Direct Conflict between ACA and FL laws*** • *Pre-existing condition exclusions are prohibited except for GF individual plans.* • *Although federal law requires certificates of creditable coverage, their primary purpose is for the application of pre-existing condition exclusions. Therefore they may no longer be necessary* • *All references to pre-existing conditions should be limited to GF individual plans only: 627.6045 Preexisting condition; 627.64871 Certification of coverage; 627.6561 Preexisting conditions; 641.31071 Preexisting conditions; 641.31 (16) Health Maintenance contracts; 641.185(h); 69O-154.105. Standards for Policy Provisions; (5) Preexisting conditions; 69O-154.110. Certificate of Creditable Coverage.; 69O-154.111. Demonstration of Creditable Coverage If Certificate is not Provided*.
Fair health insurance premiums **Effective: Plan years beginning 01/01/14**	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	Premiums may only vary by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** There are currently no provisions within the Insurance Code that would impose these rating standards for plan in FLs individual, small group, or large group markets. ***Florida Health Plans*** *The most significant conflicts that need to be addressed are the differences between the ACA regulations and FL rating rules.* • *In 2014, premiums may only vary for NGF individual and small group by: (i) family size; (ii) geography; (iii) tobacco use (1.5:1); and (iv) age (3:1). Gender is no longer a permissible rating factor.* • *There is a need to limit current rating statutes and regulations to GF plans only.*

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
	/PHSA 2701		• *There is also a need for new statutes and regulations implementing the new rating rules for NGF Individual & Small group.* *Statutes: 627.620 Misstatement of age or sex; 627.6699(6) Restrictions relating to premium rates; 627.65626 Insurance rebates for health life-styles; 641.31 (40) – healthy group rebate of premium; 69O-149.0025. Definitions.;69O-149.003. Rate Filing Procedures.; 69O-149.005. Reasonableness of Benefits in Relation to Premiums.; 69O-149.0055. Healthy Lifestyle Rebate.; 69O-149.006. Actuarial Memorandum.; 69O-149.007. Annual Rate Certification (ARC) Filing Procedures.*
Guaranteed availability of coverage **Secretary of HHS** **Effective: Plan years beginning 01/01/14**	Non-grandfathered fully-insured plans. /PHSA 2702	Insures must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • Current FL law requires guarantee issue products in the small group market (including groups of one); • FL does NOT require guarantee issue in the individual market unless the individual is HIPAA eligible (coming off COBRA, "mini-COBRA", or is not eligible for COBRA) o See s.627.6425 Renewability of individual coverage, 627.6561 – Preexisting conditions (refers to 627.6425) for Group, and 641.31071 Preexisting conditions refers to 627.6425 for Group HMOs. Mini-COBRA s. 627.6692. ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements* • *Need statute similar to the small group statute 627.6699(5) for individuals.*
Guaranteed renewability of coverage **Effective: Plan years beginning 01/01/14**	All non-grandfathered fully-insured plans. /PHSA 2703	Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • FL Insurance Code currently provides for guarantee renewable health insurance policies and HMO contracts. o See Statutes: s.627.6425 Individual; s. 627.6571 Group; s.641.31074 Group HMOs

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Prohibiting discrimination against individual participants and beneficiaries based on health status **Effective: Plan years beginning 01/01/14** **Secretary of HHS**	All non-grandfathered plans /PHSA 2705	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status; Medical condition; Claims experience; Receipt of health care; Medical history; Generic information; Evidence of insurability (including conditions arising out of domestic violence); Disability; Any other health-status related factor deemed appropriate by the Secretary HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** Current FL law prohibits unfair discrimination – see s. 626.9541 (1)(g)3. However, FL law may need to be amended to comply with eventual Federal regulations. ***Florida Health Plans*** • *New statutory authority needed to enforce new ACA requirements.*
Non-discrimination in health care **Secretary of HHS** **Effective: Plan years beginning 01/01/14**	All non-grandfathered plans /PHSA 2706	Plans may not discriminate against any provider operating within their scope of practice. Does NOT require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon whether they receive subsidies, provide information to state or federal investigators, etc. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • Generally, statutes governing participation are related to scope of benefits provided. See s. 627.419 and s. 641.19(12), et.al. • The FL Insurance Code does not currently contain anti-discrimination provisions related to receipt of subsidies (available only through an exchange) or whether a person has provided information to a federal investigator.
(*Essential Health Benefits)* Comprehensive health insurance coverage	All non-grandfathered plans /PHSA 2707	All plans must include the essential benefits package required of plans sold in the Exchanges. All plans must comply with limitations on annual cost-sharing for plans sold in the	**FL Insurance Code** The FL Ins Code does not currently define “major medical” or “comprehensive health insurance plan.” • OIR rule does define “major medical” plan for purposes of review/approval of applicable terms, conditions, and benefits. o Rule: 690-154.106(5), FAC

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Effective: Plan years beginning 01/01/14		Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21. HHS has not published complete guidance, proposed or interim regulations.	• The authority to approve contracts meeting the requirements of "essential benefits" would need to be adopted in statute with rule making authority provided to OIR. ***Florida Health Plans*** *Need (new) statutory authority to enforce new ACA requirement applicable to NGF plans for:* • *Essential Benefits* • *Small group deductible limits* • *Out-of-Pocket maximums* • *Actuarial Value* ***Mental Health*** *Direct Conflict between ACA and FL laws* • *Mental health parity (MHP) applies to the NGF individual and small group markets Mental health is an essential benefit.* • *Need to replace current MH statutes for individual, small and large group to comply with MHP and essential benefits.* • *See s. 627.668 Optional coverage for mental and nervous disorders required; exception; 627.669 Optional coverage required for substance abuse impaired persons; exception.*
Prohibition on Excessive Waiting Periods Effective: Plan years beginning 01/01/14	All group plans /PHSA 2708	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.	**FL Insurance Code** See: s. 627.6561(1)(c) • Current statutes do not contain waiting period restrictions applicable to group insurance policies.
Wellness Programs	Non-grandfathered individual	Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other	**FL Insurance Code** At s.627.6402, FL authorizes Insurance rebates for healthy lifestyles and

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Effective Plan Year 2014			
Effective: Plan years beginning 01/01/14 **Secretary of HHS**	market plans /PHSA 2705	reward upon a health status-related factor must limit such rewards to 30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. *Existing wellness programs established before March 23, 2010, may continue to be carried out.*	places a 10% cap of paid premium. At s. 626.9541(4) – under the Unfair Trade Practice Act – there are additional standards for wellness incentive program participation. **Note/FL OIR** Current laws need to be amended to conform with ACA requirements.
Coverage for individuals participating in approved clinical trials **Effective: Plan years beginning 01/01/14**	All non-grandfathered plans /PHSA 2709	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.	**FL Insurance Code** Does not currently contain provisions governing participation in clinical trials. However, there is an informal/extra-statutory "agreement" negotiated with carriers to assure payments continue for services/treatments that would otherwise be covered for a person in a clinical trial (Sen. Don Gatez announcement, 2011). ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements*
Rating reforms must apply uniformly **Effective: Plan years 01/01/14**	PPACA Sec. 1252	Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.	**FL Insurance Code** FL has made no changes in rating laws governing health insurance entities regulated by the OIR.

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Insurance Exchanges	PPACA Sections 1301-1321	States or Federal Government required to establish Insurance Exchanges in every state – to become operational for plan years beginning January 1, 2014.	**FL Insurance Code** • Florida Ins Code would need amendment to clarify the OIR's regulatory role for contracts and rates associated with a Federally Facilitated or Federal Partnership Exchange model. • FL would need guidance from HHS/CCIIO regarding clarification of regulatory role of the OIR for the solvency and consumer protection provisions of FL law that would apply to entities offering plans through an Exchange. ***Florida Health Plans – Related Issues*** ***EPO certification upon application*** *Direct Conflict between ACA and FL laws* • *Prior to or at time of sale insurer must obtain insured's signature stating they received certain required information.* • *On Exchange, there will be no mechanism to obtain signature prior to sale.* • *Need to revise statute to accommodate Exchange business.* o *627.6472(10)(11) Exclusive provider organizations* ***Grace Period on Exchange*** • *New statutory authority needed to enforce new ACA requirements.* ***Agents and Brokers*** *Direct Conflict between ACA and FL laws* • *In order to engage in the solicitation of insurance an entity must be a licensed agent; Individuals that purchase directly through the Exchange may not engage an agent prior to purchase. (See 626.112)*

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Exchange Related Provisions affecting products/issuers Outside Exchange Marketplace			
Level Playing Field **Effective: 1/1/2014**	PPACA Sec. 1324	Health insurance plans shall not be subject to any of the following state or federal laws unless Co-Op plans and multistate health plans are also subject to them: • Guaranteed renewal; Rating; Preexisting conditions; Non-discrimination; Quality improvement and reporting; Fraud and abuse; Solvency and financial requirements; Market conduct; Prompt payment; Appeals and grievances; Privacy and confidentiality; Licensure, and; Benefit plan material or information	**FL Insurance Code** **Note/FL OIR** HHS and (federal) Office of Program Management (OPM) have not reached agreement as to the extent of state regulation that will govern the two "national plans" that will be offered through insurance exchanges.
Transitional reinsurance program for individual market in each state **Effective: Plan years beginning in 2014 through 2016**	All plans must pay assessments. Non-grandfathered individual plans may receive payments. PPACA Sec. 1341	State shall enact a model regulation established by the Secretary, in consultation with the NAIC that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016. Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation. States may have more than one reinsurance entity and two or more states may enter into agreements to create entities to administer reinsurance in all such states.	**FL Insurance Code** If a state does not elect to establish a reinsurance program, the program will be administered by the HHS. **Note/FL OIR**: The reinsurance standards applicable to this program will govern the re-integration of the PCIP population back into the regulated health plan market – inside and outside an exchange program.

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Exchange Related Provisions affecting products/issuers Outside Exchange Marketplace			
Risk adjustment **Effective: 01/01/14** **Secretary of HHS, in consultation with the States**	Non-grandfathered individual and small group plans PPACA Sec. 1343	Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees have an actuarial risk that is greater than the average actuarial risk in that state.	**FL Insurance Code** There is no statutory authority for the OIR to administer a risk adjustment program for issuers with a COA in FL. **Note/FL OIR**: The risk adjustment program will be applicable to the regulated health plan market – inside and outside an exchange program.
Establishment of risk corridors for plans in individual and small group markets ***Effective: 01/01/14—for Calendar years 2014-2016*** ***Secretary of HHS, in consultation with the States***	*Qualified health plans Non-grandfathered individual and small group plans* *PPACA Sec. 1342* *1343*	*The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs.* *Plans will receive payments if their ratio of non-administrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%.* *Plans must make payments if that ratio is below 97%.*	***FL Insurance Code*** *To be administered by HHS*