

FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Friday, December 19, 2025, 3:00 PM

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 25, 2025 – Attachment**
- V. Executive Director’s Report – Attachments**
- VI. Approval of 2024 Financial Audits - Attachments**
- VII. State of the Market Annual Report Approval - Attachment**
- VIII. Discussion/Approval of Legislative Proposals for 2026 - Attachment**
- IX. Other Business**
- X. Public Comment**
- XI. Adjourn**

Attachment A

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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Term Ending: 12/31/2027
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Vacant
Agent

Vacant
Carrier

Vacant
Carrier

Vacant
Individual Policyholder

Attachment B

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD MEETING

December 2025

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
Tuesday, November 25, 2025, 4:00 PM
Via Teleconference
Tallahassee, FL**

Board Members Present:

Alexis Bakofsky, Chair
John Matthews
Eric Johnson
Seth Phelps

Nathan Landsbaum
Robert Muszynski
Karin Bailey
Rick Wallace

Richard Weiss
Vickie Whaley

Others Present:

- Jack McDermott, FHIAB Executive Director
- Christina Jackson, Deputy Director of Legal Affairs, Life & Health Product Review, Office of Insurance Regulation (OIR)

I. Call to Order

Alexis Bakofsky (Deputy Commissioner – Life & Health, Office of Insurance Regulation), as the Chair, called the meeting to order at 4:02 pm, 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, noting the presence of a quorum.

III. Antitrust Statement

Christina Jackson was recognized to review the antitrust statement.

IV. Approval of Minutes, February 11, 2025

The Chair presented the minutes from the Board's February 11, 2025, meeting and asked for questions or comments. The Chair accepted a motion from Seth Phelps to approve the minutes, seconded by Eric Johnson. The minutes were approved without changes.

V. Executive Director's Report

The Chair recognized the Executive Director for this report.

The Executive Director began by providing a brief overview of the purpose of the Florida Health Insurance Advisory Board, which was founded in 1992 as the Small Employer Health Reinsurance Program. Its purpose was to provide the state with a reinsurance mechanism. This reinsurance mechanism was last utilized in 2002 and is currently non-operational. Today, assessments are only used to cover operational costs of the Board, and therefore, the assessment amounts are nominal relative to the size of both the small group and individual marketplaces.

Financial Statements

The Executive Director then reviewed the financial statements as of October 31, 2025. As of this date, the Board had Total Assets of just over \$54,000 for the two programs after collecting and depositing annual assessments of \$59,975. The Board has enough money to sustain operations until the 2026 assessments.

Financial Audit Engagement

The Executive Director also mentioned the Audit Committee approved an audit of the 2024 financial statements that is underway. The cost of the small group audit increased from \$7,250 for 2023 to \$7,500 for 2024. The individual plan audit increased from \$3,750 for 2023 to \$3,875 for 2024. Cumulatively this represented an increase of a little over 3%, which is in line with industry standards.

The Chair asked for a motion to ratify the audit agreement. Rick Wallace moved the motion, which was seconded by Eric Johnson. The audit engagement was ratified.

VI. Other Business

The Chair then mentioned the Legislative proposals are due to the Executive Director on December 5, for consideration of the Board at the next meeting. The Executive Director will compile the recommendations and they will be published prior to the meeting. Only those recommendations reaching a full consensus by the Board members present will be submitted for consideration to the 2026 Florida Legislature on behalf of the Board.

The Chair asked if any Board members had other business. No Board member responded.

VII. Public Comment

The Chair asked if any member of the public wanted to comment. No member of the public commented.

VII. Adjourn

The Chair thanked everyone who participated especially given the proximity to the holiday weekend. Having completed the agenda, the Chair adjourned the meeting.

Prepared by: Jack McDermott, Executive Director

Approved by Board

Attachment D



OFFICE OF INSURANCE REGULATION

FILED

OCT 17 2016

OFFICE OF
INSURANCE REGULATION
Docketed by: 1093

DAVID ALTMAIER
COMMISSIONER

IN THE MATTER OF:

Case No.: 198603-16

FLORIDA HEALTH REINSURANCE PROGRAM

ORDER APPROVING AMENDMENTS TO
PLAN OF OPERATION

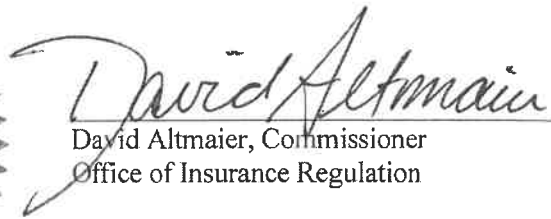
THIS CAUSE came on for consideration upon FLORIDA HEALTH REINSURANCE PROGRAM's (hereinafter referred to as "FHRP") submission to the OFFICE OF INSURANCE REGULATION (hereinafter referred to as the "OFFICE") the amendments to its Plan of Operation for review and approval, pursuant to Section 627.6699(11), 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, 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.

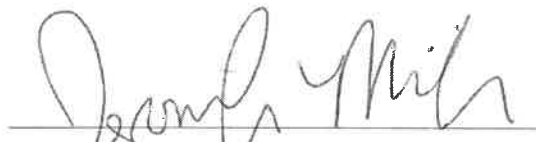
CERTIFICATE OF SERVICE

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.

A handwritten signature in dark ink, appearing to read "Jennifer Milam", is written over a horizontal line.

Jennifer A. Milam
Assistant General Counsel
Florida Bar: 89831
Florida Office of Insurance Regulation
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Florida Health Reinsurance Program

Operating as

The Florida Health Insurance Advisory Board

PLAN OF OPERATION



EXHIBIT A

Updated: July 2016

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**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 date 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/Employer/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 E

Balance Sheet
November 30, 2025
FHIAB

	Small Employer Plan	Individual Plan	Combined Total
Assets			
Cash Operating	23,168.66	14,021.58	37,190.24
Cash Depository	11,498.22		11,498.22
Cash Special Purpose	62.46		62.46
Prepaid Expenses	-	-	-
Due Between Pools	425.85	(425.85)	-
Assessments Receivable			-
Total Assets	35,155.19	13,595.73	48,750.92

Income Statement
For the Period Ended November 30, 2025
FHIAB

	Small Employer Plan	Individual Plan	Combined Total
Revenues			
Interest Income	1.06	1.28	2.34
Expense Write-off	-	-	-
Assessments	49,980.00	9,995.00	59,975.00
Total Revenues	49,981.06	9,996.28	59,977.34
Expenses			
Contract Services	45,650.00	9,350.00	55,000.00
Professional Fees	-	-	-
Meetings (Phone)**	211.24	43.27	254.51
Audit (2023)	7,250.00	3,750.00	11,000.00
Adobe Acrobat	186.66	38.23	224.89
Quickbooks*	881.46	180.54	1,062.00
PO Box	313.39	64.19	377.58
Postage	21.21	4.34	25.55
Income Taxes 2023	4.00	1.00	5.00
Avalara (Tax Prep Fees)	5.15	1.05	6.20
Total Expenses	54,523.11	13,432.62	67,955.73

*Quickbooks November Payment was delayed - not reflected here or in balance sheet

** Line1 Communications Bill of \$32.39 not reflected here as it was paid in December

Attachment F

Florida Health Insurance Advisory Board
Proposed Budget
January 1, 2026 – December 31, 2026
[12 Months]

Expense Category	2025 Estimated	2026 Proposed
Contract Management	\$60,000	\$60,000
Legal Services	\$0	\$5,000
Meeting Expenses	\$0	\$100
Miscellaneous Expenses	\$0	\$100
P.O. Box	\$378	\$390
Postage/Delivery	\$26	\$50
Supplies/Printing	\$15	\$50
Income Taxes	\$5	\$5
Adobe Writer Subscription	\$245	\$245
Telephone / Conference Call	\$400*	\$500
Quickbooks	\$1,288	\$1,400
Total Expenses to be Apportioned		\$67,840
Small Group Portion (83%)		\$56,307
Individual Portion (17%)		\$11,533

Funding (Assessment) Need

	Small Group Plan	Individual Plan
Expected Balance 12/31/2025	\$23,400	\$8,850
2026 Audit Costs (for 2025) estimated	(\$7,750)	(\$4,000)
2024 Allocated Expenses	(\$56,307)	(\$11,533)
Three-Month Reserve	(\$14,077)	(\$2,883)
Total Calculated Assessment	\$54,734	\$9,566
Recommended Assessment	\$50,000	\$10,000

**Estimate as November 25, and December 19 bill not yet known*

Attachment G

DRAFT

2024

Florida Individual Health
Reinsurance Program

Financial Statements and
Independent Auditor's Report

December 31, 2024

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITOR’S REPORT

FLORIDA INDIVIDUAL HEALTH
REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

DECEMBER 31, 2024

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INDEPENDENT AUDITOR'S REPORT

Board of Directors
Florida Individual Health Reinsurance Program
Tallahassee, Florida

Opinion

We have audited the accompanying financial statements of the Florida Individual Health Reinsurance Program (the Program), which comprise the statements of financial position as of December 31, 2024 and 2023, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Program as of December 31, 2024 and 2023, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Program and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Program's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and,

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Florida Individual Health Reinsurance Program
Tallahassee, Florida

INDEPENDENT AUDITOR'S REPORT

therefore, is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Program's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Program's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

December 19, 2025
Tallahassee, Florida

STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2024 AND 2023
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

ASSETS

	<u>2024</u>	<u>2023</u>
Assets		
Cash	\$ 14,020	\$ 14,019
Prepaid Expenses	<u>51</u>	<u>58</u>
Total Assets	<u>14,071</u>	<u>14,077</u>

LIABILITIES AND NET ASSETS

Liabilities		
Accounts Payable and Accrued Expenses	7,625	7,270
Due to Florida Small Employer Health Reinsurance Program	<u>988</u>	<u>2,051</u>
Total Liabilities	<u>8,613</u>	<u>9,321</u>
Net Assets		
Without Donor Restrictions	<u>5,458</u>	<u>4,756</u>
Total Net Assets	<u>5,458</u>	<u>4,756</u>
Total Liabilities and Net Assets	<u>\$ 14,071</u>	<u>\$ 14,077</u>

See accompanying notes.

STATEMENTS OF ACTIVITIES
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

	Without Donor Restrictions 2024	Without Donor Restrictions 2023
Revenues		
Assessment Revenue	\$ 14,992	\$ 25,276
Investment Income	<u>2</u>	<u>21</u>
Total Revenues	<u>14,994</u>	<u>25,297</u>
Expenses		
Program Services	8,854	8,779
Management and General	<u>5,438</u>	<u>5,300</u>
(Total Expenses)	<u>(14,292)</u>	<u>(14,079)</u>
Increase in Net Assets	702	11,218
Net Assets (Deficit), Beginning of Year	<u>4,756</u>	<u>(6,462)</u>
Net Assets, End of Year	<u><u>\$ 5,458</u></u>	<u><u>\$ 4,756</u></u>

See accompanying notes.

**STATEMENTS OF FUNCTIONAL EXPENSES
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA**

	December 31, 2024		
	Program Services	Management and General	Total
Expenses			
Professional Fees	\$ -	\$ 3,875	\$ 3,875
Contract Services	8,670	1,530	10,200
Meetings	10	2	12
Office Administration	174	31	205
Total Expenses	<u>\$ 8,854</u>	<u>\$ 5,438</u>	<u>\$ 14,292</u>

	December 31, 2023		
	Program Services	Management and General	Total
Expenses			
Professional Fees	\$ -	\$ 3,750	\$ 3,750
Contract Services	8,670	1,530	10,200
Meetings	42	8	50
Office Administration	67	12	79
Total Expenses	<u>\$ 8,779</u>	<u>\$ 5,300</u>	<u>\$ 14,079</u>

See accompanying notes.

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

	<u>2024</u>	<u>2023</u>
Cash Flows from Operating Activities		
Assessments Received	\$ 14,992	\$ 25,276
Amounts Paid to Small Employer Health Reinsurance Program	(14,993)	(25,276)
Interest Received	<u>2</u>	<u>21</u>
Net Cash Provided by Operating Activities	<u>1</u>	<u>21</u>
Net Increase (Decrease) in Cash	1	21
Cash, Beginning of Year	<u>14,019</u>	<u>13,998</u>
Cash, End of Year	<u><u>\$ 14,020</u></u>	<u><u>\$ 14,019</u></u>

See accompanying notes.

**NOTES TO FINANCIAL STATEMENTS
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA**

Note 1 - Organization

The Florida Individual Health Reinsurance Program (the Program) is established by Section 627.6475, Florida Statutes, for the purpose of ensuring coverage for individuals who are eligible for individual health insurance pursuant to Section 627.7487(3), Florida Statutes (eligible individuals).

The Program operates subject to the control and supervision of the Board of Directors of the Small Employer Health Reinsurance Program (the Board) established pursuant to Section 627.6699(11), Florida Statutes. During the 2005 legislative session, this statute was amended to require the Board to advise the Office of Insurance Regulation, other executive departments, and the legislature on health insurance issues. As part of these changes, the composition of the Board was changed to include the employer representatives, an individual purchaser, and a representative of the Agency for Health Care Administration.

All insurers issuing individual health insurance, as defined in Section 627.6487(2), Florida Statutes, are members of the Program. Members have limited rights in that they have no control or voting rights in the Program. Any funds held by the Program upon its termination, after payment of all claims and expenses of the Program, shall be distributed to the Program's members existing at that time in accordance with the then-existing assessment formula.

The Program has the ability to reinsure health benefit coverage, as specified in the law, for eligible individuals. The Plan of Operation establishes all policies and procedures of the Program, including the methods of assessing members, collecting premiums, and paying claims. Currently, there are no individuals participating in the reinsurance program. The Program's current activities are advisory in nature.

Note 2 - Significant Accounting Policies

Basis of Presentation

Financial statement presentation follows *Accounting Standards Codification (ASC) 958-205, Financial Statements for Not-For-Profit Organizations*. Under ASC 958-205, the Program is required to report information regarding its financial position and activities as follows:

■ **Without Donor Restrictions**

Net assets that are not subject to donor-imposed stipulations.

■ **With Donor Restrictions**

Net assets subject to donor-imposed stipulations that may or will be met either by actions of the Program and/or passage of time. When a restriction expires, net assets with donor restrictions are reclassified to without donor restrictions and are reported in the statements of activities as net assets released from restrictions.

Functional Allocation of Expenses

The cost of the Program has been summarized on a functional basis in the statements of activities. Expenses that are directly identifiable with a specific program or initiative are charged to that program. Expenses that relate to both programs and general operations of the Program are allocated based on management's best estimates of time spent or benefits provided.

**NOTES TO FINANCIAL STATEMENTS
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA**

Cash

Cash of the Program consists of various accounts, which are held at one financial institution. Accounts are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. As of December 31, 2024 and 2023, accounts did not exceed FDIC deposit insurance limits.

Assessments

Assessments are administered by the Program based on budgeted operating needs. Members are assessed in accordance with Florida Statutes and the Plan of Operation. Assessment revenues are recorded at the time of billing to members. The Program annually reviews assessment collections and operating expenditures to reconcile final assessment action. All assessments are considered to be collectible; therefore, no allowance for credit losses is provided for in the financial statements. Assessment revenues were \$14,992 and \$25,276 during 2024 and 2023, respectively.

Federal Income Taxes

The Program currently files its federal tax returns as a membership organization under Section 277 of the Internal Revenue Code. This section requires the Program to pay tax on either net member income or investment income. The Program may take deductions attributable to providing goods and services to members to the extent of member income. Any excess deductions can be carried forward to future years. No deferred tax asset is currently recorded because the asset is not expected to be realized. For the tax years 2024 and 2023, the Program was taxed on investment income. Income tax expense for the years ended December 31, 2024 and 2023, was not material.

Under ASC Subtopic 740-10, *Income Tax Uncertainties*, it is the policy of management to evaluate its tax positions on an ongoing basis and to disclose any such positions it believes would have a material impact on the financial statements and related notes. Management believes there are no uncertain tax positions taken, or expected to be taken, that would require recognition of an asset or liability, or disclosure in the financial statements.

The Program is no longer subject to U.S. federal or state income tax examinations by tax authorities for years before the 2021 tax year. The Program recognizes interest accrued related to unrecognized tax benefits in interest expense and penalties, if any, in operating expenses.

Accounting Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of the revenues and expenses during the reporting period. Actual results may differ from estimates.

Subsequent Events

The Program has evaluated subsequent events and transactions for potential recognition or disclosure in the financial statements as of the date the financial statements were available to be issued.

NOTES TO FINANCIAL STATEMENTS
FLORIDA INDIVIDUAL HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

Note 3 - Related-Party

The Florida Small Employer Health Reinsurance Program, an organization affiliated through common board membership and shared cost arrangements, pays certain expenses on behalf of the Program, primarily related to office and program administration expenses, and is subsequently reimbursed for its payments. Amounts due to the Florida Small Employer Health Reinsurance Program for the years ended December 31, 2024 and 2023, were \$988 and 2,051, respectively.

Note 4 - Liquidity and Availability of Financial Assets

The following reflects the Program’s financial assets as of the balance sheet date, reduced by amounts not available for general use because of contractual or donor-imposed restrictions within one year of the balance sheet date:

	<u>2024</u>	<u>2023</u>
Program’s Financial Assets, at December 31:		
Cash	\$ <u>14,020</u>	\$ <u>14,019</u>
Total Financial Assets	<u>14,020</u>	<u>14,019</u>
Program’s Financial Assets Available to Meet Cash		
Needs for Expenditures Within One Year	<u>\$ <u>14,020</u></u>	<u>\$ <u>14,019</u></u>

Note 5 - Subsequent Events

In February 2025, the Board approved assessments to its members totaling \$60,000 for the fiscal year ending December 31, 2025. Of this amount, \$10,000 is to be apportioned to the Program. As of the reporting date, over 99% of this amount has been collected.

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COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Board of Directors
Florida Individual Health Reinsurance Program
Tallahassee, Florida

We have audited the financial statements of the Florida Individual Health Reinsurance Program (the Program) for the year ended December 31, 2024, and have issued our report thereon dated December 19, 2025. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter dated October 7, 2025. Professional standards require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Program are described in Note 2 to the financial statements. No new accounting policies were adopted, and the application of existing policies was not changed during 2024. We noted no transactions entered into by the Program during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the financial statements was:

- Allocation of expenses among program and support services, which is based on estimates of time spent on program and support activities.

We evaluated the methods, assumptions, and data used to develop the estimate described above in determining that it is reasonable in relation to the financial statements taken as a whole. The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

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Tallahassee, Florida

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Certain adjustments were needed to convert the accounting records from cash to accrual basis. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, a disagreement with management is a disagreement on financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated December 19, 2025.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Program's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards with management each year prior to retention as the Program's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Directors and management of the Program and is not intended to be, and should not be, used by anyone other than these specified parties.

December 19, 2025
Tallahassee, Florida

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Board of Directors
Florida Individual Health Reinsurance Program
Tallahassee, Florida

In planning and performing our audit of the financial statements of the Florida Individual Health Reinsurance Program (the Program), as of and for the year ended December 31, 2024, in accordance with auditing standards generally accepted in the United States of America, we considered the Program's system of internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Program's internal control. Accordingly, we do not express an opinion on the effectiveness of the Program's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we identified a certain deficiency in internal control that we consider to be a significant deficiency.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency or a combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the Program's financial statements will not be prevented, or detected and corrected, on a timely basis. We did not identify any deficiencies in internal control that we consider to be material weaknesses.

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider item 24-01 in the attached Summary of Audit Findings and Recommendations to be a significant deficiency.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the Program, and is not intended to be, and should not be, used by anyone other than these specified parties.

The Program's written response to the significant deficiency identified in our audit has not been subjected to the audit procedures applied in the audit of the financial statements, and, accordingly, we do not express an opinion on it.

December 19, 2025
Tallahassee, Florida

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SUMMARY OF AUDIT FINDINGS AND RECOMMENDATIONS

- ***24-01**—During 2024, the Program’s financial records were kept using manual cash receipt and disbursement ledgers. We recommend the Program develop procedures to ensure the books and records are maintained using a formalized double-entry accounting system and include the identification and posting of year-end accruals.

* Indicates findings or recommendations that were present in prior years.

Program Response

The Program accepts the above recommendation and is actively working towards rectifying this finding. The Program is in the process of implementing a formalized double-entry bookkeeping system.

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2024

Florida Small Employer Health
Reinsurance Program

Financial Statements and
Independent Auditor's Report

December 31, 2024

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITOR’S REPORT

FLORIDA SMALL EMPLOYER HEALTH
REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

DECEMBER 31, 2024

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INDEPENDENT AUDITOR'S REPORT

Board of Directors
Florida Small Employer Health Reinsurance Program
Tallahassee, Florida

Opinion

We have audited the accompanying financial statements of the Florida Small Employer Health Reinsurance Program (the Program), which comprise the statements of financial position as of December 31, 2024 and 2023, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Program as of December 31, 2024 and 2023, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Program and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Program's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with generally accepted auditing

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Florida Small Employer Health Reinsurance Program
Tallahassee, Florida

INDEPENDENT AUDITOR'S REPORT

standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Program's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Program's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

December 19, 2025
Tallahassee, Florida

STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2024 AND 2023
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

ASSETS

	<u>2024</u>	<u>2023</u>
Assets		
Cash	\$ 42,709	\$ 64,421
Prepaid Expenses	249	258
Due from Florida Individual Health Reinsurance Program	<u>988</u>	<u>2,051</u>
Total Assets	<u><u>43,946</u></u>	<u><u>66,730</u></u>

LIABILITIES AND NET ASSETS

Liabilities

Accounts Payable and Accrued Expenses	<u>14,750</u>	<u>14,195</u>
Total Liabilities	<u>14,750</u>	<u>14,195</u>

Net Assets

Without Donor Restrictions	<u>29,196</u>	<u>52,535</u>
Total Net Assets	<u>29,196</u>	<u>52,535</u>
Total Liabilities and Net Assets	<u><u>\$ 43,946</u></u>	<u><u>\$ 66,730</u></u>

See accompanying notes.

STATEMENTS OF ACTIVITIES
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

	Without Donor Restrictions 2024	Without Donor Restrictions 2023
Revenues		
Assessment Revenue	\$ 34,992	\$ 74,697
Interest Income	<u>1</u>	<u>18</u>
Total Revenues	<u>34,993</u>	<u>74,715</u>
Expenses		
Program Services	43,207	42,865
Management and General	<u>15,125</u>	<u>14,815</u>
(Total Expenses)	<u>(58,332)</u>	<u>(57,680)</u>
Change in Net Assets	(23,339)	17,035
Net Assets, Beginning of Year	<u>52,535</u>	<u>35,500</u>
Net Assets, End of Year	<u><u>\$ 29,196</u></u>	<u><u>\$ 52,535</u></u>

See accompanying notes.

**STATEMENTS OF FUNCTIONAL EXPENSES
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA**

	December 31, 2024		
	<u>Program Services</u>	<u>Management and General</u>	<u>Total</u>
Expenses			
Professional Fees	\$ -	\$ 7,500	\$ 7,500
Contract Services	42,330	7,470	49,800
Meetings	48	9	57
Office Administration	829	146	975
Total Expenses	<u>\$ 43,207</u>	<u>\$ 15,125</u>	<u>\$ 58,332</u>

	December 31, 2023		
	<u>Program Services</u>	<u>Management and General</u>	<u>Total</u>
Expenses			
Professional Fees	\$ -	\$ 7,250	\$ 7,250
Contract Services	42,330	7,470	49,800
Meetings	208	37	245
Office Administration	327	58	385
Total Expenses	<u>\$ 42,865</u>	<u>\$ 14,815</u>	<u>\$ 57,680</u>

See accompanying notes.

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

	<u>2024</u>	<u>2023</u>
Cash Flows from Operating Activities		
Cash Paid to Vendors for Services	\$ (56,705)	\$ (45,667)
Assessments Received	34,992	74,697
Interest Received	<u>1</u>	<u>18</u>
Net Cash (Used in) Provided by Operating Activities	<u>(21,712)</u>	<u>29,048</u>
Net (Decrease) Increase in Cash	(21,712)	29,048
Cash, Beginning of Year	<u>64,421</u>	<u>35,373</u>
Cash, End of Year	<u><u>\$ 42,709</u></u>	<u><u>\$ 64,421</u></u>

See accompanying notes.

**NOTES TO FINANCIAL STATEMENTS
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA**

Note 1 - Organization

The Florida Small Employer Health Reinsurance Program (the Program) is a not-for-profit entity created under the *Employee Health Care Access Act* (the Act), Section 627.6699 of the Florida Statutes, for the purposes of assuring the availability of appropriate health care coverage to Florida residents on an affordable basis and to provide a reinsurance mechanism to facilitate the provision of small employer coverage.

During the 2005 legislative session, the Act was amended to require the Program to advise the Office of Insurance Regulation, other executive departments, and the legislature on health insurance issues. As part of these changes, the composition of the Board of Directors of the Program was changed to include employer representatives, an individual purchaser, and a representative of the Agency for Health Care Administration.

All insurers, as defined in Section (5)(a) of the Act, issuing health insurance or providing health plan benefits in Florida on or after January 1, 1993, are members of the Program. Members have limited rights in that they have no control or voting rights in the Program. Any funds held by the Program upon its termination, after payment of all claims and expenses of the Program, shall be distributed to the Program's members existing at that time in accordance with the then-existing assessment formula.

The Program has the ability to reinsure health benefit coverage, as specified in the law, after consideration of applicable deductibles, of small employers' eligible employees and their dependents. The Plan of Operation establishes all policies and procedures of the Program, including the methods of assessing members, collecting premiums, and paying claims. Currently, there are no small employers participating in the reinsurance program. The Program's current activities are advisory in nature.

Note 2 - Significant Accounting Policies

Basis of Presentation

Financial statement presentation follows *Accounting Standards Codification* (ASC) 958-205, *Financial Statements for Not-For-Profit Organizations*. Under ASC 958-205, the Program is required to report information regarding its financial position and activities as follows:

■ **Without Donor Restrictions**

Net assets that are not subject to donor-imposed stipulations.

■ **With Donor Restrictions**

Net assets subject to donor-imposed stipulations that may or will be met either by actions of the Program and/or passage of time. When a restriction expires, net assets with donor restrictions are reclassified to without donor restrictions and are reported in the statements of activities as net assets released from restrictions.

Functional Allocation of Expenses

The cost of the Program has been summarized on a functional basis in the statements of activities. Expenses that are directly identifiable with a specific program or initiative are charged to that program. Expenses that relate to both programs and general operations of the Program are allocated based on management's best estimates of time spent or benefits provided.

NOTES TO FINANCIAL STATEMENTS
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

Cash

Cash of the Program consists of various bank accounts, which are held at one financial institution. Accounts are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. As of December 31, 2024 and 2023, accounts did not exceed FDIC deposit insurance limits.

Assessments

Assessments are administered by the Program based on budgeted operating needs. Members are assessed in accordance with Florida Statutes and the Plan of Operation. Assessment revenues are recorded at the time of billing to members. The Program annually reviews assessment collections and operating expenditures to reconcile final assessment actions. All assessments are considered to be collectible; therefore, no allowance for credit losses is provided for in the financial statements. Assessment revenues were \$34,992 and \$74,697 during 2024 and 2023, respectively.

Federal Income Taxes

The Program currently files its federal tax returns as a membership organization under Section 277 of the Internal Revenue Code. This section requires the Program to pay tax on net member income and investment income. The Program may take deductions attributable to providing goods and services to members to the extent of member income. Any excess deductions can be carried forward to future years. No deferred tax asset is currently recorded because the asset is not expected to be realized. For the tax years 2024 and 2023, the Program is taxed on investment income. Income tax expense for the years ended December 31, 2024 and 2023, was not material.

Under ASC Subtopic 740-10, *Income Tax Uncertainties*, it is the policy of management to evaluate its tax positions on an ongoing basis and to disclose any such positions it believes would have a material impact on the financial statements and related notes. Management believes there are no uncertain tax positions taken or expected to be taken that would require recognition of an asset or liability, or disclosure in the financial statements.

The Program is no longer subject to U.S. federal or state income tax examinations by tax authorities for years before the 2021 tax year. The Program recognizes interest accrued related to unrecognized tax benefits in interest expense and penalties, if any, in operating expenses.

Accounting Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of the revenues and expenses during the reporting period. Actual results may differ from estimates.

Subsequent Events

The Program has evaluated subsequent events and transactions for potential recognition or disclosure in the financial statements as of the date the financial statements were available to be issued.

NOTES TO FINANCIAL STATEMENTS
FLORIDA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
TALLAHASSEE, FLORIDA

Note 3 - Related-Party

The Program pays certain expenses on behalf of the Florida Individual Health Reinsurance Program, an organization affiliated through common board membership and cost-sharing arrangements. These expenses are primarily related to office and program administration expenses and are subsequently reimbursed for such payments. Amounts due from the Florida Individual Health Reinsurance Program for the years ended December 31, 2024 and 2023, were \$988 and \$2,051, respectively.

Note 4 - Liquidity and Availability of Financial Assets

The following reflects the Program’s financial assets as of the balance sheet date, reduced by amounts not available for general use because of contractual or donor-imposed restrictions within one year of the balance sheet date.

	<u>2024</u>	<u>2023</u>
Program’s Financial Assets, at December 31:		
Cash	\$ 42,709	\$ 64,421
Due from Florida Individual Health Reinsurance Program, Net	<u>988</u>	<u>2,051</u>
Total Financial Assets	<u>43,697</u>	<u>66,472</u>
Program’s Financial Assets Available to Meet Cash Needs for Expenditures Within One Year	<u>\$ 43,697</u>	<u>\$ 66,472</u>

Note 5 - Subsequent Events

In February 2025, the Board of Directors approved assessments to its members totaling \$60,000 for the fiscal year ending December 31, 2025. Of this amount, \$50,000 is to be apportioned to the Program. As of the reporting date, over 99% of this amount has been collected.

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COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Board of Directors
Florida Small Employer Health Reinsurance Program
Tallahassee, Florida

We have audited the financial statements of the Florida Small Employer Health Reinsurance Program (the Program) for the year ended December 31, 2024, and have issued our report thereon dated December 19, 2025. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter dated October 7, 2025. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Program are described in Note 2 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during 2024. We noted no transactions entered into by the Program during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the financial statements was:

- Allocation of expenses among program and support services, which is based on estimates of time spent on program and support activities.

We evaluated the methods, assumptions, and data used to develop the estimate described above in determining that it is reasonable in relation to the financial statements taken as a whole. The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

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Board of Directors
Florida Small Employer Health Reinsurance Program
Tallahassee, Florida

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Certain adjustments were needed to convert the accounting records from cash to accrual basis. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, a disagreement with management is a disagreement on a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated December 19, 2025.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Program's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards with management each year prior to retention as the Program's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Directors and management of the Program, is not intended to be, and should not be, used by anyone other than these specified parties.

December 19, 2025
Tallahassee, Florida

Board of Directors
Florida Small Employer Health Reinsurance Program
Tallahassee, Florida

In planning and performing our audit of the financial statements of the Florida Small Employer Health Reinsurance Program (the Program), as of and for the year ended December 31, 2024, in accordance with auditing standards generally accepted in the United States of America, we considered the Program's system of internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Program's internal control. Accordingly, we do not express an opinion on the effectiveness of the Program's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we identified a deficiency in internal control that we consider to be a significant deficiency.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency or a combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the Program's financial statements will not be prevented, or detected and corrected, on a timely basis. We did not identify any deficiencies in internal control that we consider to be material weaknesses.

A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider item 24-01 in the attached Summary of Audit Findings and Recommendations to be a significant deficiency.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the Program, and is not intended to be, and should not be, used by anyone other than these specified parties.

The Program's written response to the significant deficiency identified in our audit has not been subjected to the audit procedures applied in the audit of the financial statements and, accordingly, we do not express an opinion on it.

December 19, 2025
Tallahassee, Florida

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SUMMARY OF AUDIT FINDINGS AND RECOMMENDATIONS

- ***24-01**—During 2024, the Program’s financial records were kept using manual cash receipt and disbursement ledgers. We recommend the Program develop procedures to ensure the books and records are maintained using a formalized double-entry accounting system and include the identification and posting of year-end accruals.

* Indicates findings or recommendations that were present in prior years.

Program Response

The Program accepts the above recommendation and is actively working towards rectifying this finding. The Program is in the process of implementing a formalized double-entry bookkeeping system.

Attachment H

2025 FLORIDA HEALTH INSURANCE MARKET REPORT

BY THE

FLORIDA HEALTH INSURANCE ADVISORY BOARD

December 19, 2025

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 with a specific focus on the individual and small group markets.

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, 2024. Previous reports are available on the FHIAB section of the Office's website at: <https://flor.com/life-health/florida-health-insurance-advisory-board>.

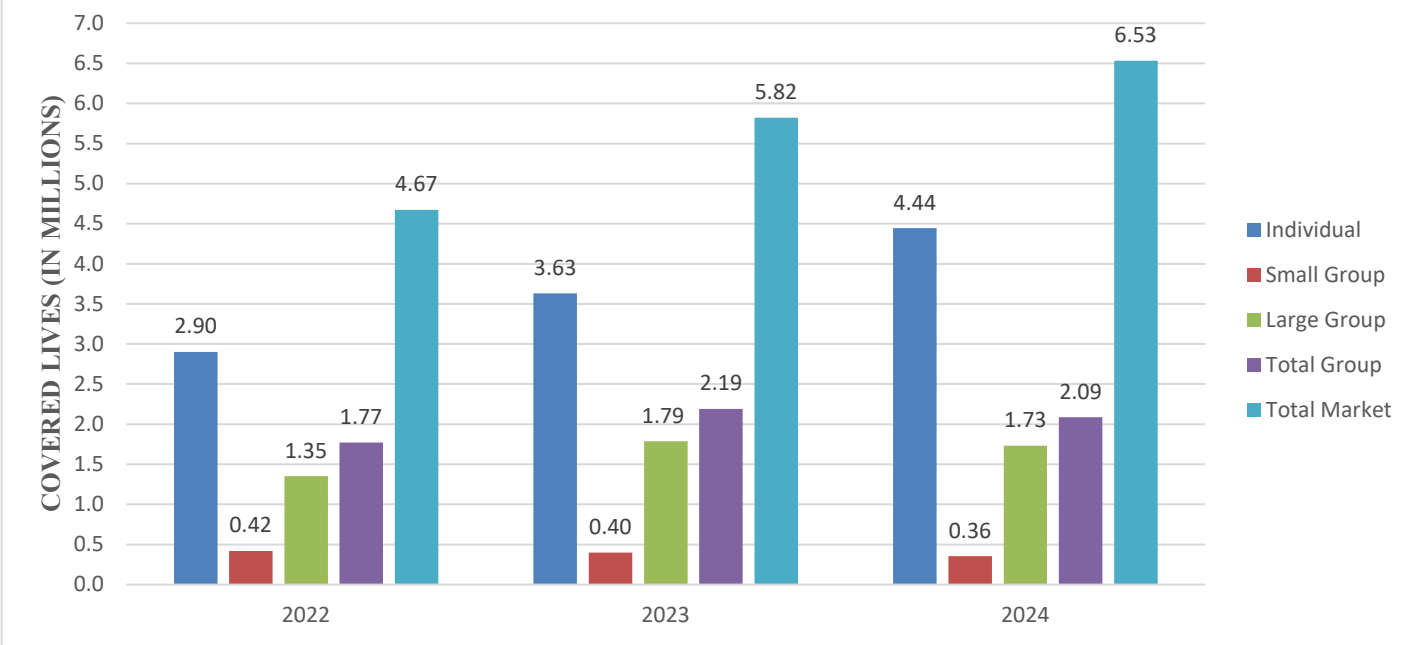
Executive Summary

Overall enrollment continued to grow, with gains in the individual market significantly offsetting losses in the small group and large group markets. The losses in the small group market were more pronounced than in the past. The long-term trend of increasing individual enrollment and decreasing group enrollment continued in CY 2024 after stabilizing in CY 2023, mostly due to large group market gains.

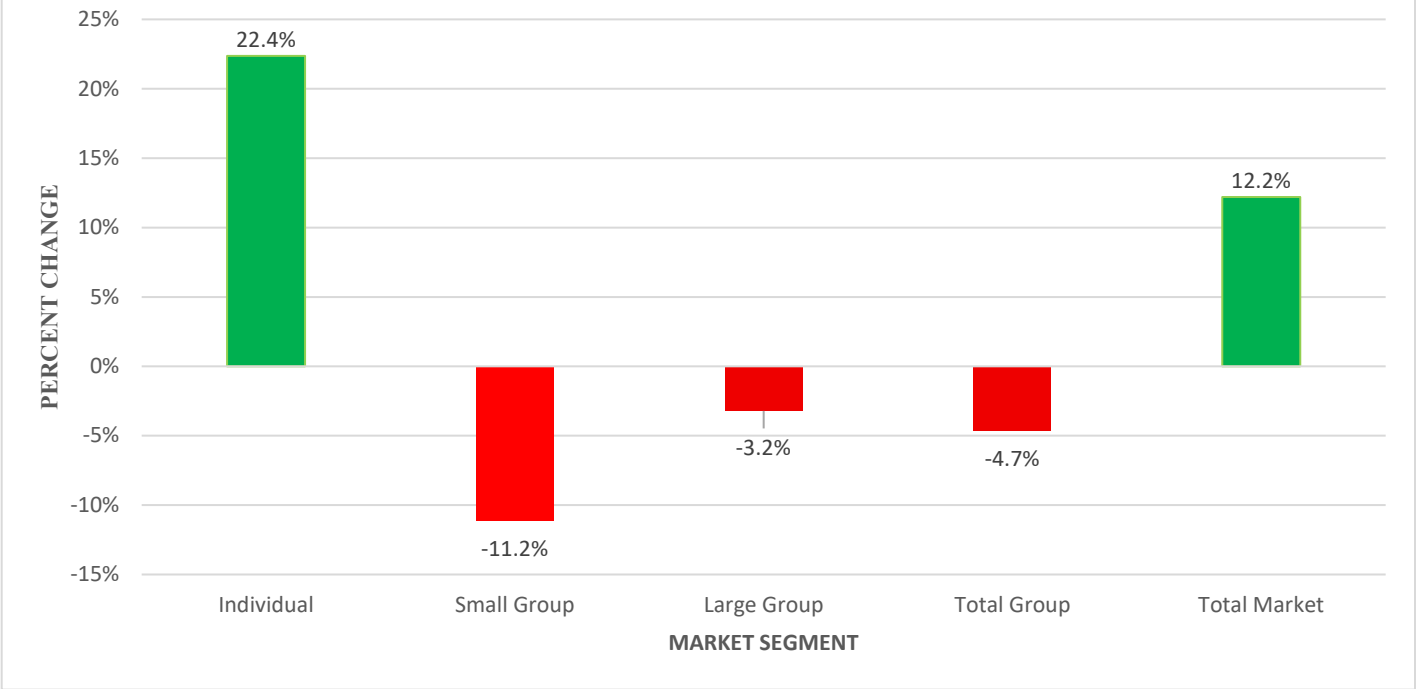
Today, in the State of Florida, people covered under individual policies exceed those covered under a group policy. Under the Affordable Care Act (ACA), all individual policies must be guaranteed issue; no application can be rejected based on the health status of the applicant. The individually underwritten 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, most individual policyholders have moved to an ACA-compliant policy due to the subsidies available on the Federal Marketplace, reducing the market share of both grandfathered and transitional policies.

Commercial Enrollment

Enrollment by Market Segment
Plan Years 2022-2024



Enrollment Change by Market Segment
Plan Years 2023-2024



As illustrated above and shown in Table 1 below, total enrollment in Florida's commercial health insurance markets increased in 2024 by 710,165 covered lives or 12.2%. This follows an increase from the previous year of 1,149,698 covered lives or 24.6%. The overall market remains significantly larger than before the ACA, and the trend of large year-over-year increases continues in 2024.

As of year-end 2024, coverage by market segment consisted of:

- **Individual Coverage** – 4,444,258, an increase of 812,385 covered lives or 22.4%
- **Small Group** (1-50 members) – 355,416, a decrease of 44,748 covered lives or 11.2%
- **Large Group** (51+ members) – 1,731,869, a decrease of 57,472 covered lives or 3.2%
- **Total Market** – 6,531,543 an increase of 710,165 covered lives or 12.2%

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). 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.

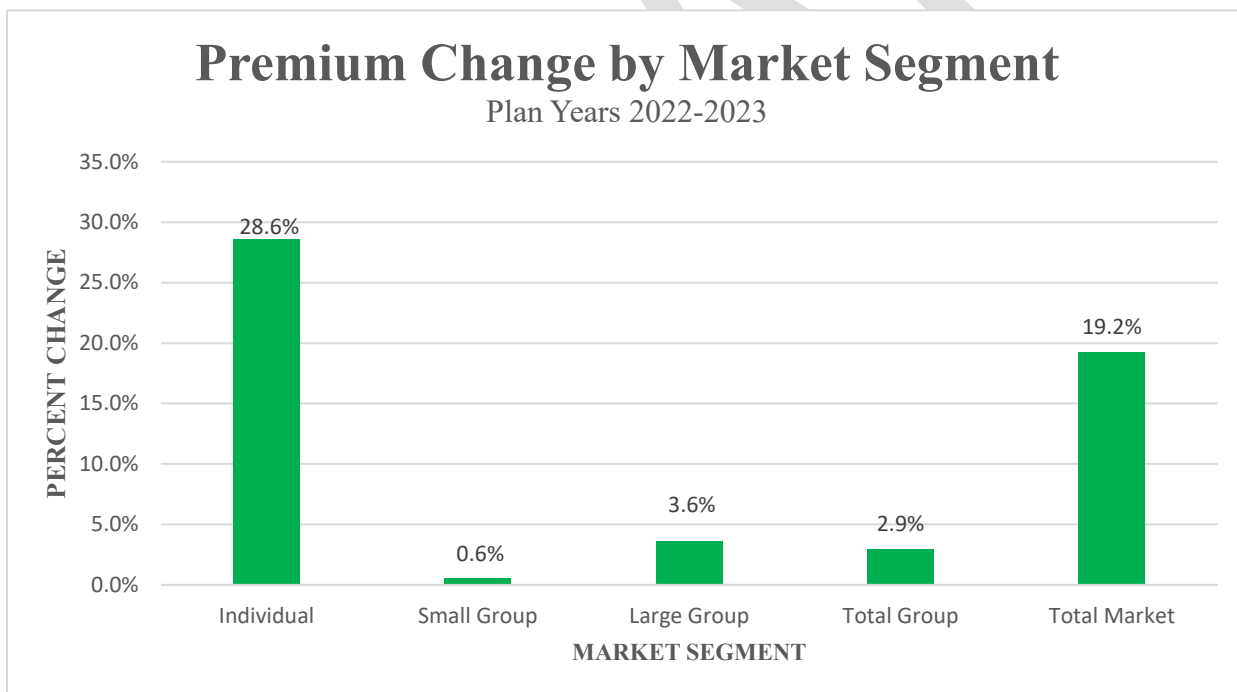
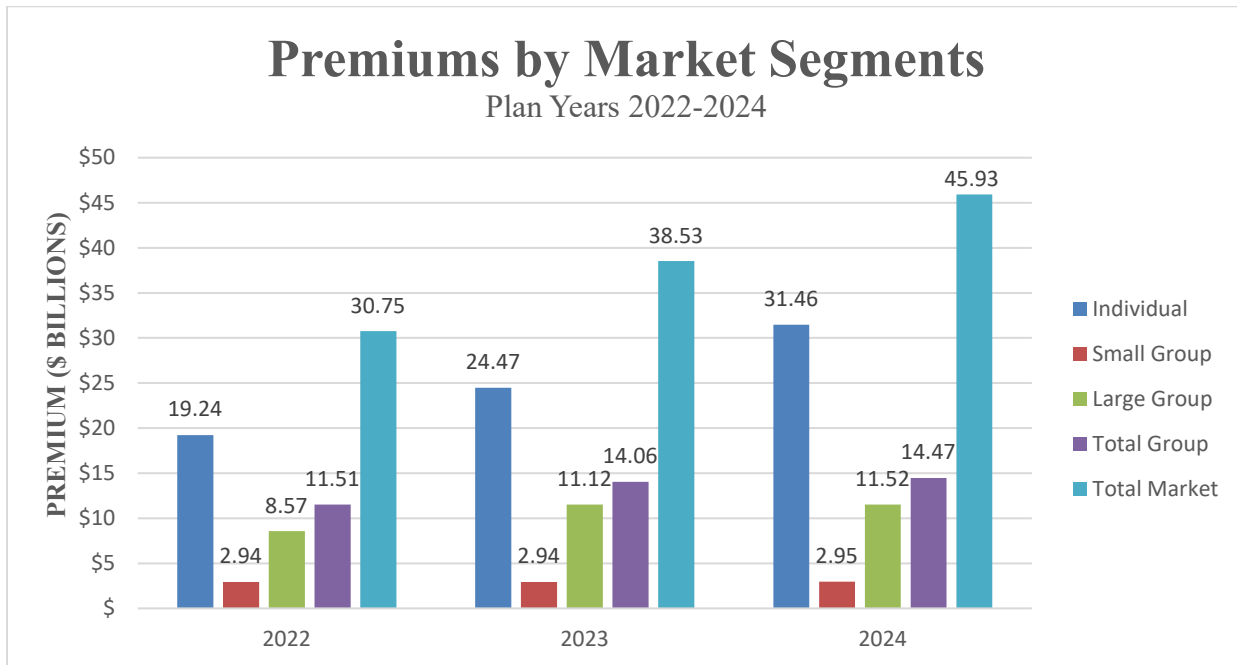
In 2021, the individual market overtook the group market in terms of enrollment – which accelerated dramatically since 2021. This trend has continued through 2023 and 2024 supported by enhanced subsidies and Medicaid disenrollments. The 2024 data continues to show a decline in small group coverage in Florida, and the pace of this decline appears to have increased.

Federal legislation could be influencing this outcome. In 2021 the U.S. Congress passed the American Rescue Plan which included enhanced premium tax credits to make purchasing ACA policies more affordable. These tax credits were extended by the Inflation Reduction Act of 2022, but are set to expire at the end of 2025; as of the date of this report, the U.S. Congress has not extended these tax credits, which could change the current market dynamic of a growing individual market, and shrinking small group market in 2026 and beyond.

Table 1
Commercial Insurance Enrollment 2022-2024

Market Segments	2022	2023	2024
Individual Guaranteed Issue			
ACA On-Exchange	2,630,125	3,310,945	4,181,639
ACA Off-Exchange	185,310	245,384	194,769
Grandfathered (In-State and Out-of-State)	246	219	189
Transitional (In-State and Out-of-State)	20	20	13
Total Guaranteed Issue	2,815,701	3,556,568	4,376,610
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	27,334	23,176	19,934
Transitional (In-State and Out-of-State)	57,203	51,507	47,138
Total Individually Underwritten	84,537	74,683	67,072
Conversion			
Total Conversion	106	622	576
Small Groups (1-50)			
Self-Employed or Sole Proprietor	57	92	66
2 – 50 Member Groups	420,219	400,072	355,350
Total Small Groups	420,276	400,164	355,416
Large Groups (51+)			
Total Large Groups	1,351,060	1,789,341	1,731,869
Market Totals			
Total Individual Market	2,900,344	3,631,873	4,444,258
Total Group Market	1,771,336	2,189,505	2,087,285
Total Commercial Market	4,671,680	5,821,378	6,531,543

Commercial Premium

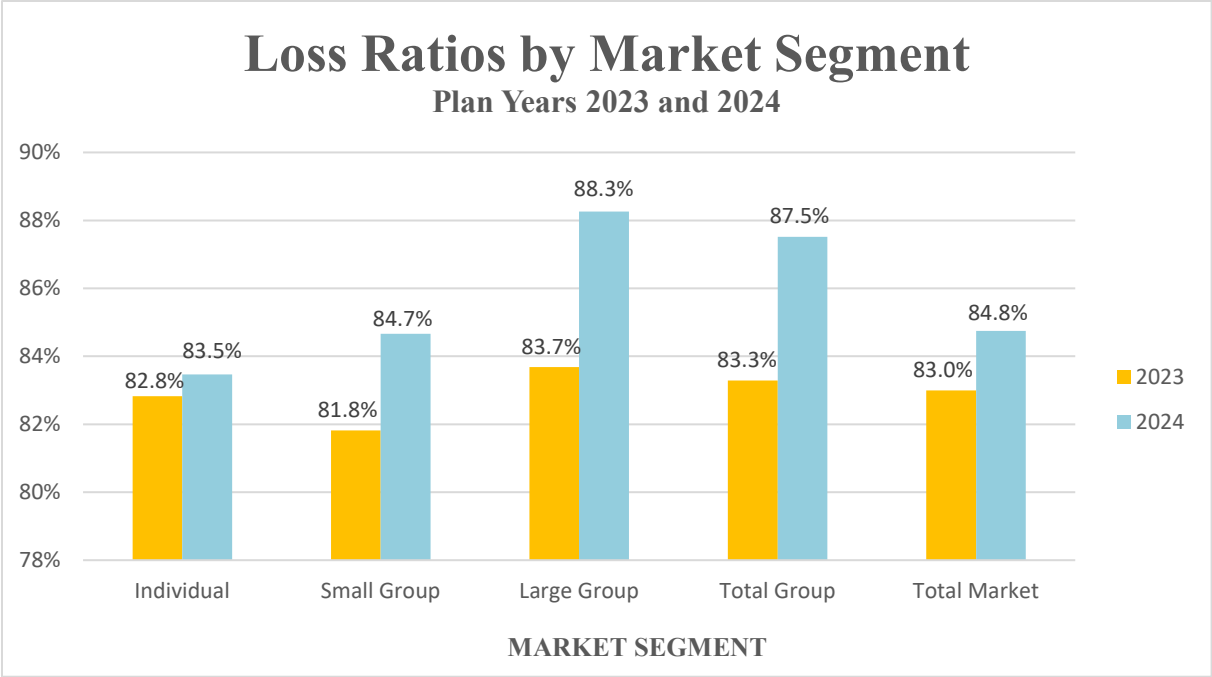


As illustrated above and shown in Table 2 below, the overall commercial market generated \$45.9 billion in premiums in 2024, a 19.2% increase from 2023. The increase is mostly the result of the higher enrollment in the individual market, and higher premiums per member in all markets.

Table 2
Commercial Insurance Premium 2022-2024

Market Segments	2022	2023	2024
Individual Guaranteed Issue			
Grandfathered (In-State and Out-of-State)	\$451,948	\$372,565	\$343,471
Transitional (In-State and Out-of-State)	\$331,912	\$343,604	\$302,654
ACA On-Exchange	\$17,534,106,462	\$22,793,815,445	\$29,918,240,013
ACA Off-Exchange	\$1,162,947,165	\$1,174,948,187	\$1,109,971,747
Total Guaranteed Issue	\$18,703,174,317	\$23,969,479,801	\$31,028,857,885
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	\$196,782,090	\$182,096,799	\$165,193,134
Transitional (In-State and Out-of-State)	\$337,867,456	\$317,232,850	\$269,883,696
Total Individually Underwritten	\$534,649,546	\$499,329,649	\$435,076,830
Conversion			
Total Conversion	\$1,095,243	\$944,604	\$591,568
Small Groups (1 – 50)			
Self-Employed or Sole Proprietor	\$577,277	\$834,340	\$650,394
2 – 50 Member Groups	\$2,944,225,548	\$2,934,320,568	\$2,950,850,073
Total Small Groups	\$2,944,802,825	\$2,935,154,908	\$2,951,500,467
Large Groups (51+)			
Total Large Groups	\$8,566,575,785	\$11,121,412,029	\$11,518,924,076
Market Totals			
Total Individual Market	\$19,238,919,106	\$24,469,754,054	\$31,464,526,282
Total Group Market	\$11,511,378,610	\$14,056,566,937	\$14,470,424,542
Total Commercial Market	\$30,750,297,716	\$38,526,320,991	\$45,934,950,824

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 increased “across-the-board” in all categories, with the largest increase in large group, followed by small group, then individual.

In the individual market, the overall loss ratio increased from 82.8% in 2023 to 83.5% in 2024 while the small group overall loss ratio increased from 81.8% in 2023 to 84.7% in 2024.

The large group market experienced an overall loss ratio increase from 83.7% in 2023 to 88.3% in 2024. 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 2023-2024

Market Segments	2023			2024		
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)	\$372,565	\$601,053	161.33%	\$343,471	\$476,235	138.65%
Transitional (In-State and Out-of-State)	\$343,604	\$515,388	149.99%	\$302,654	\$177,409	58.62%
ACA On-Exchange	\$22,793,815,445	\$18,990,592,886	83.31%	\$29,918,240,013	\$24,950,524,923	83.40%
ACA Off-Exchange	\$1,174,948,187	\$862,240,002	73.39%	\$1,109,971,747	\$908,152,584	81.82%
Total Guaranteed Issue	\$23,969,479,801	\$19,853,949,328	82.83%	\$31,028,857,885	\$25,862,188,394	83.35%
Individually Underwritten						
Grandfathered (In-State and Out-of-State)	\$182,096,799	\$142,715,314	78.37%	\$165,193,134	\$134,279,919	81.29%
Transitional (In-State and Out-of-State)	\$317,232,850	\$270,893,905	85.39%	\$269,883,696	\$263,819,874	97.75%
Total Individually Underwritten	\$499,329,649	\$413,609,219	82.83%	\$435,076,830	\$398,099,793	91.50%
Conversion						
Total Conversion	\$944,604	\$1,663,164	176.07%	\$591,568	\$3,083,148	521.18%
Small Groups (1 – 50)						
Self-Employed or Sole Proprietor	\$834,340	\$1,122,109	134.49%	\$650,394	\$1,330,341	204.54%
2 – 50 Member Groups	\$2,934,320,568	\$2,400,554,783	81.81%	\$2,950,850,073	\$2,497,500,253	84.64%
Total Small Groups	\$2,935,154,908	\$2,401,676,892	81.82%	\$2,951,500,467	\$2,498,830,594	84.66%
Large Groups (51+)						
Total Large Groups	\$11,121,412,029	\$9,306,250,718	83.68%	\$11,518,924,076	\$10,166,399,132	88.26%
Market Totals						
Total Individual Market	\$24,469,754,054	\$20,269,221,712	82.83%	\$31,464,526,282	\$26,263,371,335	83.47%
Total Group Market	\$14,056,566,937	\$11,707,927,609	83.29%	\$14,470,424,542	\$12,665,229,726	87.52%
Total Commercial Market	\$38,526,320,991	\$31,977,149,321	83.00%	\$45,934,950,824	\$38,928,601,061	84.75%

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 1, 2025, follows:

**FLORIDA HEALTH INSURANCE ADVISORY
BOARD OF DIRECTORS**

Alexis Bakofsky, Chair Designee

Deputy Commissioner – Life & Health
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Karin Bailey

Chief, Bureau of Plan Management
Operations
Agency for Health Care Administration
2727 Mahan Drive, MS #26
Tallahassee, FL 32308

Christina Lake

Executive Vice President
Datamaxx Group, Inc.
2001 Drayton Drive
Tallahassee, FL 32311
Term Ending: 12/31/2027

William "Bill" Herrle

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

Eric Johnson, PhD, 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
261 N University Drive
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: 12/31/2028

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*One director position designated for
agents and one for an individual
policyholder are vacant.*

Attachment I

Proposal # 1: Deductible and Out-of-Pocket Carryover for Mid-Year Carrier Plan Changes

Vickie Whaley, REBC – Independent Agent

Florida residents insured under individual plans who move to a new zip code or are otherwise required to switch plans within the same carrier during the plan year often lose the credit they have accumulated toward their deductible and out-of-pocket maximum. This results in consumers paying duplicate cost-sharing amounts despite maintaining continuous coverage with the same insurer.

These resets create significant financial burdens for individuals and families and disproportionately affect:

- Members relocating for work or personal reasons
- Individuals with chronic health conditions or ongoing treatment
- Families experiencing medical events early in the plan year
- Members in rural areas where available plans differ by zip code

There is currently no statutory requirement in Florida mandating carriers to transfer accumulator balances (deductible, co-insurance, copays, and pharmacy cost shares) when a plan change occurs within the same carrier during the same plan year.

□ Recommendation: Add section 627.6428, Florida Statutes, to address continuity of deductible and out-of-pocket accumulators for individual health insurance policies. This requirement would apply only to individual health insurance coverage offered on or off the federal Marketplace, including plans offered by insurers and HMOs, and does not apply to employer-sponsored group health plans.

Proposal # 2: Expand Direct Payer Arrangements Using Technology Platforms

Vickie Whaley, REBC – Independent Agent

Rising health care costs, limited transparency, and fragmented care delivery continue to drive poor outcomes and higher premiums for employers, insurers, and patients. Current statutory frameworks allow for limited direct primary care agreements between providers and patients but do not account for broader, technology-enabled care coordination models that integrate multiple service types (primary care, behavioral health, functional medicine, compounding pharmacy, and musculoskeletal care) within a unified platform.

Technology now exists to securely connect patients with multiple provider types, manage shared electronic health records accessible by all treating providers and the patient, and provide cost transparency across the continuum of care. Employer-sponsored health plans and carriers seek innovative models that align payment, improve provider-patient connectivity, reduce overhead, and incentivize holistic care across primary care, functional health, compounding pharmacy, musculoskeletal, and behavioral health services. However, there is no clear statutory authority allowing employers or carriers to sponsor such direct payer models while maintaining compliance with Florida insurance law and Medicare standards.

□ *Recommendation: Create section 624.28 Florida Statutes, authorizing employer- or carrier-sponsored Direct-Payer Technology Platform Arrangements. The purpose of these changes would include:*

- *Definition of a technology-enabled platform as a secure, interoperable system connecting patients and licensed providers across multiple disciplines with a shared patient record.*
- *Permitting employers and insurers to contract directly with providers or provider networks through such platforms for designated services (primary care, behavioral health, functional health, compounding pharmacy, musculoskeletal care).*
- *Require compliance with federal Medicare and HIPAA standards, including certified electronic health record interoperability under s. 408.051, F.S.*
- *Ensure transparency through patient access to costs, outcomes, and real-time record sharing.*
- *Allow flexible payment models (capitated, bundled, or value-based) to encourage care coordination and cost control.*
- *Direct the Office of Insurance Regulation and Agency for Health Care Administration to develop certification and reporting standards for these platforms, ensuring consumer protection and oversight.*

By providing this statutory authority, Florida can encourage innovation in employer and carrier plan design, reduce administrative waste, and support lower-cost, patient-centered health care delivery.

Proposal # 3: Expansion of Carrier Reporting Requirements to Improve Employer Access to Claims and Premium Data

Vickie Whaley, REBC – Independent Agent

Rising health care costs continue to place pressure on Florida employers regardless of size. Despite bearing significant expense related to providing affordable minimum essential coverage to employees, employers receive limited claims transparency, preventing them from identifying cost drivers or pursuing targeted cost-containment strategies.

Under existing Florida statutes, reporting requirements from health insurers and HMOs are inconsistent, narrow in scope, and often unavailable to employers upon request. Many carriers provide only high-level summaries or utilization indicators, and HMOs are not required to disclose detailed cost categories such as pharmacy, inpatient, outpatient, or capitated care.

This gap restricts an employer's ability to engage in effective benefits planning, results in less informed decision-making, and ultimately contributes to higher premiums for Florida's workforce. De-identified claims information is already collected by carriers for actuarial purposes; however, employers rarely receive it in a useful, standardized format.

Other states including California, Texas, Colorado, and North Carolina have expanded transparency to support employer cost management. Florida employers would benefit from similar baseline reporting.

□ Recommendation: Add section 627.6385, Florida Statutes, or creation of new statute under Part VII – Health Insurance to address data reporting requirements. This modification would require all group health benefit plans to provide an annual report to plan sponsors, upon request, that includes at minimum:

(a) Premium and Financial Information:

- *Total premiums paid for fully-insured and level-funded arrangements.*
- *Total claims paid.*
- *Medical loss ratio for the group.*

(b) Category-Level Claims Information: De-identified aggregated claims data broken out into the following categories:

- *Pharmacy services, including specialty drug spend.*
- *Outpatient services, including emergency room, urgent care, laboratory, imaging, and ambulatory surgery.*
- *Inpatient services, including admissions, length of stay, and average allowed cost.*
- *Capitated services, including primary care, specialty care, and other professional capitation arrangements.*

(c) High-Cost Claimants:

De-identified aggregated information summarizing the number of claimants exceeding cost thresholds of \$50,000 and \$100,000 annually, along with grouped diagnostic categories without personal identifiers.

All data must comply with the de-identification standards under 45 C.F.R. §164.514 and must not contain Protected Health Information as defined by federal law. Carriers may not charge employers a fee for the preparation or delivery of the required report. Reports should be provided within 30-calendar days of the request.

Proposal # 4: Underwriting Transparency Requirements for Health Insurance Carriers

Vickie Whaley, REBC – Independent Agent

Florida has implemented several transparency measures over the past decade, such as claims reporting thresholds, medical loss ratio requirements, and disclosure obligations under federal rules (e.g., Transparency in Coverage and the Consolidated Appropriations Act).

However, none of these laws require carriers to disclose how premiums are calculated. Employers routinely receive renewal rates without insight into:

- How demographic or claims risk factors were weighted
- Which trend assumptions were applied
- What underwriting models or algorithms were used
- How adjustments for experience rating, credibility, pooling charges, fees, or manual rates were applied

This lack of transparency creates an information imbalance between insurers and employer plan sponsors, especially small and mid-sized employers who lack bargaining leverage or access to full claims data.

As a result, employers cannot verify whether renewal increases are justified, competitive, or aligned with their group's risk. It also inhibits Florida's broader goals of cost containment, data-driven benefit decisions, and fostering competitive insurance markets.

□ Recommendation: Amend section 627.6699 and Part I of Chapter 641 (for HMOs), Florida Statutes, to require that all health insurance carriers and HMOs offering group coverage provide employers, upon request or at renewal, with a standardized Underwriting Basis of Rating Disclosure (UBRD).

The UBRD would include:

- *Summary of Rating Methodology Used, including whether manual, experience, blended, or community rating was applied.*
- *Trend Assumptions used in developing rates (medical, Rx, utilization).*
- *Credibility Formula applied to the employer's claims experience.*
- *Risk Adjustment or Risk Scoring Model used (not proprietary algorithms, but the factors and categories used).*
- *Breakdown of Rating Components, such as:*
 - *Base rate*
 - *Demographic risk factors*
 - *Claims experience adjustments*
 - *Pooling charges or large-claim factors*
 - *Administrative load*
 - *Commissions or fixed fees*

The report would be deidentified, contain no personal health information, and would not require disclosure of proprietary formulas—only the inputs and factors applied to the employer group.

Proposal # 5: Expanding After-Hours Access for Medicaid Participants Through Technology-Enabled Concierge and Direct-Payer Care Models

Vickie Whaley, REBC – Independent Agent

Florida Medicaid beneficiaries continue to face significant barriers accessing primary care and behavioral health services during evenings, weekends, and other after-hours periods. Provider shortages, rural geographic limitations, and long appointment wait times leave many patients without timely care options, resulting in avoidable emergency department utilization and increased state expenditures.

Technology-enabled concierge and direct-access care models allow beneficiaries to connect with licensed providers across multiple disciplines, access real-time virtual care, and maintain a centralized electronic health record used by all treating providers. These models have demonstrated strong results in commercial markets, improving access, reducing unnecessary emergency room visits, and strengthening continuity of care. However, current Florida statutes do not explicitly authorize Medicaid managed care plans to implement such arrangements, limiting their ability to modernize access pathways and meet the needs of underserved populations.

This proposal also directly supports Florida's implementation of the Federal ACCESS Program (Advancing Care for Chronic Conditions and Everyday Support), which requires states to strengthen appointment availability, increase after-hours care options, improve behavioral health access, reduce avoidable emergency department utilization, enhance transparency, and implement robust access reporting. Technology-enabled concierge models are a strong fit with these federal requirements and can help Florida meet upcoming ACCESS compliance deadlines.

□ *Recommendation: Amend section 409.973, Florida Statutes, to add a subsection that provides AHCA explicit authority to approve, contract for, or pilot technology-enabled, concierge-style after-hours care models within Medicaid managed care to expand access, improve care coordination, and support compliance with CMS's ACCESS Program requirements. Such authorization should include:*

- *Use of technology-enabled platforms connecting Medicaid beneficiaries with licensed providers for after-hours primary care, behavioral health, musculoskeletal care, pharmacy consultation, and functional health services.*
- *Centralized, interoperable electronic health records shared among all treating providers to support continuity of care and ACCESS transparency standards.*
- *Flexible payment structures, including capitated, bundled, or value-based models, compliant with CMS actuarial soundness requirements.*
- *Pilot programs targeted to rural counties, behavioral health shortage areas, and high-utilization populations to address ACCESS-required network adequacy and appointment availability.*
- *Reporting of access measures, wait times, beneficiary experience, and avoidable emergency department utilization consistent with CMS ACCESS performance and transparency rules.*
- *Compliance with HIPAA, the Florida Electronic Health Records Exchange Act, and all federal Medicaid requirements.*

Proposal # 6: Expansion of Pharmacy Benefit Manager Reporting Requirements to Employer Plan Sponsors

Vickie Whaley, REBC – Independent Agent

While Florida's 2023 Prescription Drug Reform Act (SB 1550) established substantial oversight of Pharmacy Benefit Managers (PBMs), current statutory requirements do not provide employers with consistent access to detailed financial information related to PBM activities.

PBMs control a significant portion of prescription drug costs through rebate negotiations, spread pricing, pharmacy reimbursements, and retained fees. Employers, who carry fiduciary responsibility for their benefit plans, often lack visibility into these cost structures, inhibiting their ability to evaluate plan value, identify cost drivers, or ensure that PBM practices align with Florida's cost-containment goals.

Several gaps remain:

- Reporting is directed primarily to regulators, not employers.
- Fully insured employers receive limited or no PBM-level financial detail.
- There is no standardization of reporting elements or data formats, resulting in inconsistent or incomplete information.
- No requirement exists for PBMs to provide employer-specific financial disclosures upon request.

To address these gaps, Florida should expand PBM reporting obligations to include standardized employer-requested disclosures, similar to emerging national models such as California SB 41.

□ Recommendation: Creation of new section in Chapter 626, Florida Statutes for employer reporting and transparency requirements for pharmacy benefit managers. This section would require PBMs operating in Florida to provide detailed, standardized annual reports to employer plan sponsors upon request.

PBMs must provide upon request, a standardized annual report including:

- *Total rebates received and passed through*
- *Rebate retention percentage*
- *All fees charged to the employer*
- *Any remuneration received from manufacturers*
- *Spread between pharmacy reimbursement and plan billing*
- *Top 25 drugs with plan cost, pharmacy reimbursement, and rebate details*
- *Specialty and mail-order drug pricing*
- *340B claim differentials*
- *Network arrangements including preferred vs. non-preferred pharmacy terms*
- *Ownership or conflict-of-interest disclosures.*

All data shared with the employer remains protected under trade-secret confidentiality. Employers may share the information only as needed for fiduciary, actuarial, audit, and procurement purposes. PBMs and Carriers are not allowed to charge employers a fee for the preparation or delivery of the required report. Reports should be provided within 30-calendar days of the request.