FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Tuesday, October 12, 2021, 2:00 PM
Conference Call
Call-In Number: 866-299-7949
Code: 4288083#

AGENDA

I. Call to Order

II. Roll Call – Attachment

III. Antitrust Statement – Attachment

IV. Chair's Opening Remarks

V. Approval of Minutes, August 24, 2021 – Attachment

VI. Executive Director Selection Committee Status Report - Attachment

VII. Review of Plan of Operation - Attachment

VIII. Discussion of Legislative Proposals for 2022 – Attachment

IX. Other Business

X. Public Comment

XI. Adjourn

FLORIDA HEALTH INSURANCE ADVISORY BOARD

September 21, 2021

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Carrier

Vacant
Agent

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD MEETING

October 12, 2021

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.

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Tuesday, August 24, 2021, 2:00 PM
Via Teleconference
Tallahassee, FL

Board Members Present:

Mike Yaworsky, Chair Designee	Ken Stevenson, Vice Chair	Cody Farrill
Louisa McQueeney	Christina Lake	William "Bill" Herrle
Richard B. Weiss	John J. Matthews	Seth M. Phelps
Rick Wallace	Robert Muszynski	

Others Present:

- Amy Hardee, Administrative Assistant II to the Deputy Commissioner – Life & Health, Office of Insurance Regulation (OIR)
- Monica Ross, Chief Legal Counsel, OIR

I. Call to Order

Mike Yaworsky (Chief of Staff, Office of Insurance Regulation) announced that he had been appointed as the Chair's designee for this meeting by Commissioner and Chair David Altmaier. The Chair then called the meeting to order at 2:00 pm indicating that the meeting was properly noticed to the public in accordance with Florida Law.

II. Roll Call

Amy Hardee conducted a roll call, noting the presence of a quorum.

III. Antitrust Statement

Monica Ross was recognized and reviewed the antitrust statement.

IV. Chair's Opening Remarks

The Chair thanked the members for their attendance.

The Chair also noted that Molly McKinstry, the Agency for Health Care Administration (ACHA) representative who joined the Board in July 2014, is no longer with AHCA so Cody Farrill (Chief of Staff, AHCA) has been appointed to serve in her stead.

V. Approval of Minutes, December 18, 2020

The Chair presented the minutes from the December 18, 2020, meeting for adoption, noting that members had been provided with advance copies. Bill Herrle moved to adopt the minutes as written, with a second by Ken Stevenson, and the minutes were adopted without objection.

VI. Executive Director Selection Committee Status Report

The Chair recapped the Board's approved motion from its last meetings and turned the time over to Seth Phelps (Chair, Executive Director Selection Committee) for a status report following the Committee's July 1 meeting.

Mr. Phelps reported that the Committee voted to utilize the existing job description and previous posting materials from last year in the initial search and to post the position in at least three online locations for 21 days:

1. FHIAB webpage of the OIR website (https://www.floir.com/)
2. LinkedIn.com
3. NAAIA.org (National African American Insurance Association)

Based on the above and Mr. Phelps' additional research following the Committee Meeting, Mr. Phelps motioned for the following:

- Re-post the Executive Director position for 21 days: Christina Lake seconded
- With OIR assistance, as needed, create a LinkedIn account for the FHIAB and post the Executive Director position on that website as well as on the FHIAB webpage of the OIR website at no cost: Richard Weiss seconded
- Post the Executive Director position on NAAIA website for 30 days at a cost of $199: Rick Wallace seconded

The above motions were adopted without objection.

Board members will be advised of the advertisements once posted so they can help spread the word and encourage qualified individuals they may know to apply, including previous applicants. Mr. Phelps will also reach out directly to the President of the NAAIA's Florida Chapter for assistance in circulating the advertisement to Florida members. Mr. Phelps also noted that the Florida Association of Health Underwriters (FAHU) has a limited job posting capability, which he believes is at no cost. The chair noted that no motion was necessary for board members to take individual actions; however, they were reminded of their obligation to act in an appropriate manner.

The Chair thanked Mr. Phelps for the report and the Committee's work so far.

VII. Annual Audits

The Chair presented the 2019 Audit Reports for the Individual and Small Employer Health Reinsurance Programs, which were prepared by Purvis Gray, noting that members had been provided with advance copies. These reports have been reviewed and approved by the Audit Committee. John Matthews moved to adopt, with a second by Richard Weiss, and the reports were adopted without objection.

The Chair presented the draft Audit Engagement Letter for the 2020 Audit by Purvis Gray, noting that members had been provided with advance copies. The Chair noted that the fees are the same as past years, and that the letter has been reviewed and approved by the Audit Committee. Seth Phelps moved to adopt, with a second by John Matthews, and the recommendation was adopted without objection.

VIII. Other Business

The Chair noted that the Board will be receiving an email soon asking for legislative proposals for 2022. These proposals will be discussed at the next meeting with voting taking place at a follow-up meeting.

The Chair asked if there was any other business to be brought before the Board. There being none, the Chair moved to the next agenda item.

IX. Public Comment

The Chair asked if there were any members of the public who would like to comment. There being none, the Chair moved to the next agenda item.

X. Adjourn

The Chair thanked everyone for participating. Having no further business, the meeting was adjourned at 2:28 pm.

_____ _____

Mike Yaworsky, Chair Designee Date

Executive Director – Florida Health Insurance Advisory Board

The successful candidate in this Executive Director level position will be responsible for providing administrative support to the FHIAB Board and its constituent members. The position is an independent contractor position.

Job Duties Include But Are Not Limited To

- Administrative support and preparation for FHIAB Board meetings. This includes:
  - Preparing an annual budget and monthly financial statements comparing budget to actual expenses. Providing variance analysis and preparing and distributing quarterly statements to all Board members and generally maintaining the financial books and records of the Board.
  - Scheduling and planning meetings of the Board and any committees. Developing meeting agendas in consultation with Board Chairman. Arranging physical facilities (if necessary). Preparing meeting materials and providing to Board members in advance of meetings and appropriate formal notice through the Florida Administrative Weekly. The Board typically meets 4-6 times annually.
  - Taking and preparing meeting minutes.
  - Assisting the Board in the selection of independent auditors, legal counsel, and other persons necessary for the Board in the performance of its duties.
  - Coordinating with external consultants such as auditors and financial advisors in the preparation of any required Internal Revenue Service tax filings.
  - Preparing the FHIAB annual Board report, annual health insurance market report and any other reports as may be required by statute or directed by the Board.
  - Coordinate with the Florida Office of Insurance Regulation regarding uploading information (i.e., Florida Channel tapes, meeting information including agendas & minutes, etc.) to the FHIAB website.
- Efficient Operation of the FHIAB
  - Recommending changes to the Board in statutes, Plan of Operation, etc., related to FHIAB responsibilities and activities. Work with FHIAB legal counsel to draft new documents and implement changes.
  - Consultation with the Office of Insurance Regulation (OIR), Department of Financial Services (DFS), Agency for Health Care Administration (AHCA), the Legislature and other interested parties as necessary on Board initiatives. Monitor legislation affecting the FHIAB or the health insurance marketplace. Provide input to the Board on proposed legislation.
  - Assisting the Board in developing legislative recommendations pertaining to the Florida health insurance marketplace.
  - Monitoring current events and provide the Board with salient information on a regular basis.

Job Requirements

- Demonstrated skills in accounting, finance, bookkeeping and other skills necessary to track to and manage a small budget.
- Demonstrated computer skills in utilizing the following programs MS Excel, MS Word, and e-mail.
- Excellent written and verbal presentation skills.
- Strong interpersonal skills, including the ability to communicate effectively and develop and maintain strong interpersonal relationships.
- Ability to work independently without supervision to accomplish job duties. The Board has no additional independent contractors or employees.

Preferred

- Experience working in and understanding of the health insurance marketplace in Florida.
    - This includes a working understanding of the health insurance laws and regulations applicable to the individual, small group, and large group marketplaces in Florida.
- Demonstrated experience working with public boards in Florida.
- An understanding of the Florida government in the Sunshine Law.

To Apply

Please submit your resume to FHIAB@floir.com by no later than COB _____.

Florida Health Reinsurance Program

Operating as

The Florida Health Insurance Advisory Board

PLAN OF OPERATION

Updated: July 2016

Table of Contents

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

Article I – Purpose

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

The purposes of the Program are:

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

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

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

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

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

Article II - Definitions

As used in this Plan:

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

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

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

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

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

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

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

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

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

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

1. who is not eligible for coverage under:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. a Special Enrollment Period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article III - Program Provisions Applicable to Certain Carriers

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

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

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

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

Article IV - Powers of the Program

The Program has the general powers and authority granted under the laws of Florida to insurance companies and Health Maintenance Organizations licensed to transact business except the power to issue Health Benefit Plans directly to groups or individuals. In addition, the Program has the specific authority to:

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

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

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

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

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

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

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

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

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

Article V - Plan of Operation

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

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

C. The Program operates for the benefit of both types of Reinsuring Carriers who issue coverage as required under the Acts. For Small Employer Reinsuring Carriers, the statutory requirement involves offering a Basic and Standard Health Benefit Plan as well as other Small Employer Health Benefit Plans, to all Eligible Small Employers.

For Individual Reinsurance Carriers, the statutory requirement involves offering at least two generally available coverages, as described in section (4) of the Individual Act. The Small Employer Plans and the Individual Plans shall be offered without regard to health status or claim experience. The Board shall provide additional clarification of Carrier requirements under the Acts, as needed.

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

Article VI - Board of Directors and Meetings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. The Board shall hold other meetings upon the request of the Chairman or of three or more Directors, at appropriate times and frequency. These meetings may be held in person, by telephone, or by a written vote circulated to the Directors, upon which the Directors will indicate in writing their rejection or approval of the measure at issue. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors at least 7 days prior to the meeting.

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

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

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

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

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

L. Executive Director

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

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

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

Article VII – Conflict of Interest, Ethics

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

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

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

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

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

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

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

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

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

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

G. Any breach of conflict of interest, post-employment restrictions, other ethics policies or suspected fraud or compromise of public trust by the Executive Director or members of the Board shall be reported by the executive Director to the Chair of the Board immediately upon discovery. If such breach constitutes potential criminal activity, the full circumstances shall also be reported by the Executive Director to the Department of Financial Services, Division of Insurance Fraud within 48 hours of discovery.

Article VIII - Committees

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

Committees may include the following:

A. Actuarial Committee

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

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

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

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

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

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

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

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

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

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

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

B. Audit Committee

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

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

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

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

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

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

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

Article IX - Administering Carrier: Selection and Duties

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

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

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

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

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

b. On a timely basis, collect reinsurance premium for ceded risks and all other amounts due to the Program. Unless modified by the Board, a "timely basis" is defined to mean receiving premium within 30 days of due date. If the premium is not received within 10 days after the 30 days expires, the Administering Carrier, if any, shall send a late notice demanding payment (including interest and penalties if appropriate) within 20 days. The Administering Carrier, if any, shall be notified in writing of any modification to this time schedule by the Board.

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

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

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

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

4. Perform other functions as directed by the Board.

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

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

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

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

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

Article X – Small Employer Eligibility for Reinsurance

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

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

A. Identifying Eligible Small Employers

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

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

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

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

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

B. Identifying Eligible Health Benefit Plans

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

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

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

C. Identifying Eligible Employees and Dependents

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

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

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

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

D. Late Enrollee Provisions

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

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

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

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

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

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

Article XI – Individual Eligibility for Reinsurance

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

A. Identifying Eligible Individuals

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

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

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

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

4. When an Individual Carrier offers coverage to an Eligible Individual, if the plan offered covers dependents, the coverage must be offered to all of the Eligible Individual's Eligible Dependents. If the dependent is not also an Eligible Individual, the Plan may impose a Pre-existing Condition Limitation, unless prohibited by applicable state or federal law.

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

B. Identifying Eligible Health Benefit Plans

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

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

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

Article XII – Procedures for Ceding Risks

A. Reinsurance Rules and Premium Levels

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. The Reinsuring Carrier may reinsure individual coverage of an Eligible Employee without reinsuring coverage of any specific Dependent of that employee, and may reinsure coverage of a specific Eligible Dependent without reinsuring coverage of the Employee. A newborn's coverage may be reinsured only if the mother's coverage was reinsured prior to the date of birth.

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

B. Notification of Reinsurance

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

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

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

C. Period of Reinsurance

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

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

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

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

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

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

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

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

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

D. Determination of Reinsurance Premium

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

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

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

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

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

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

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

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

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

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

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

d. Reinsurance rates vary by plan:

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

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

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

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

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

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

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

actuarial committee (the High Benefit Plan and the Low Benefit Plan);

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

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

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

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

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

c. Reinsurance rates vary by plan:

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

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

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

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

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

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

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

E. Billing and Payment

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

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

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

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

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

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

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

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

6. Reinsurance premium is due to the Program for as long as the Benefit Plan remains in force, regardless of the Reinsuring Carrier's ability to collect the Small Employer's or Eligible Individual's premiums. The Program has no responsibility for the Reinsuring Carrier's collection of premiums.

Article XIII - Reinsurance Claims

A. Statement of Reinsurance

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

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

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

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

   a. Claim adjudication expenses.

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

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

   d. Any amount paid by Reinsuring Carriers for:

      (1) Punitive or exemplary damages; or

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

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

e. Any statutory penalty imposed upon a Reinsuring Carrier.

B. General Requirements

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

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

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

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

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

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

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

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

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

10. A 60-day re-submission period exists for claims denied by an Administering Carrier or the Program. If the Reinsuring Carrier determines that the 60-day period is insufficient and this re-submission deadline cannot be met, the Reinsuring Carrier must notify an Administering Carrier or the Program in writing. This written notification must include a description of the circumstances involved, as well as the reason for the extension request. Such requests will then be presented to the board for review. When a claim is denied, an Administering Carrier or the Program shall notify the Reinsuring Carrier that the claim is denied. The notice shall include the reason(s) for denial, a statement that the Reinsuring Carrier has 60-days to resubmit the claims with information necessary to process the claim and information on submitting a request for an extension to the 60-day resubmission period. During this 60-day period or any extension thereof, an Administering Carrier or the Program shall maintain a record of the claim.

C. Claims Reporting

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

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

Article XIV – Assessments and Procedures for Collecting Assessments

A. Net Fund Earnings

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

B. Assessments on Reinsuring Carriers (First Tier)

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

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

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

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

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

C. Residual (Second Tier) Assessments

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

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

D. Assessment Deferral

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

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

E. De Minimus Assessments

Any assessment of less than $10 shall be forgiven.

F. Late Payments

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

G. Earned Premium

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

H. Board's Administrative Assessment

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

I. Interim Assessments

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

J. Assessment Administration

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

Article XV - Reporting Requirements

A. All Carriers

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

2. The Program shall notify an Administering Carrier, if any, upon the election to become a risk-assuming or reinsuring carrier by a Small Employer Carrier, as provided in the Small Employer Act or by an Individual Carrier, as provided in the Individual Act, including the approval date and period of election.

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

B. All Small Employer and Individual Carriers

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

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

C. Reinsuring Carriers

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

a. Identification of the Reinsuring Carrier;

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

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

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

e. Plan anniversary date;

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

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

h. Effective date of Small Employer coverage;

i. Effective date of reinsurance;

j. Date of applicable employee's employment;

k. Status code as required by the Board; and

l. Other information required by the Board.

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

a. Identification of the Reinsuring Carrier;

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

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

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

e. Plan anniversary date;

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

g. Effective date of coverage;

h. Effective date of reinsurance;

i. Status code as required by the Board; and

j. Other information required by the Board.

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

a. The reinsured's name and identification number

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

c. Effective date of status change

d. Status code for change as required by the Board

e. Other information required by the Board

Article XVI - Financial Administration

A. Books and Records

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

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

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

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

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

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

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

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

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

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

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

   g. Other records required by the Board.

B. Handling and Accounting of Assets and Money

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

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

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

C. Lines of Credit

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

D. Investment Policy

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

Article XVII - Audit Functions

A. Audits of Reinsuring Carriers and Reinsurance Claims

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

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

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

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

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

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

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

b. Reinsurance premiums submitted to the Program, including:

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

(2) Proper determination of reinsurance premiums paid.

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

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

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

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

B. Audits of the Program

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

This audit shall encompass at least the following items:

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

2. The annual fiscal report of the Program.

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

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

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

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

Article XVIII - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

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

2. Errors related to reinsurance:

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

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

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

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

   c. Reinsuring Carrier reinsures incorrect claim payments.

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

3. Errors related to assessments:

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

4. Errors not listed:

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

5. Gross negligence and intentional misconduct:

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

B. Interest and Administrative Charges

All interest payments required under this Article shall be calculated at 1.5% per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. All or some of the administrative charge and/or interest charge may be waived by the Board. Errors reported by Reinsuring Carriers within 90 days of their occurrence shall not be subject to interest or administrative charge.

C. Limitation on Premium Refund

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

D. Appeal of Disputes

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

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

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

Article XIX - Indemnification

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

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

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

D. The Program shall indemnify each member of the Board, each member of any committee or any subcommittee of the Board, the Executive Director and the estate, executor, administrator, heirs, legatees and devisees of any such person (such persons and entities being herein called "Indemnified Parties") against judgments, including interest, fines, amounts paid or agreed upon in settlement, reasonable costs and expenses, including attorneys' fees, and any other liability that may be incurred as a result of any claim, action, suit or proceeding, whether civil, criminal, administrative or otherwise, prosecuted or threatened to be prosecuted (collectively, the "Legal Cost"), for or on account of any act performed or omitted or obligation entered into, if done or omitted in good faith without intent to defraud and within what the Indemnified Party reasonably believed to be the scope of the Indemnified Party's employment and authority and for a purpose which the Indemnified Party reasonably believed to be in the best interest of and in connection with the administration, management, conduct or affairs of the Program or the Board, and with respect to any criminal actions or proceedings, in addition had no reasonable cause to believe that the Indemnified Party's conduct was unlawful. Provided, however, that if any such claim, action, suit or proceeding is compromised or settled, it must be done so with the prior and express approval of the Board.

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

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

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

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

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

Article XX - Amendment, Termination

A. Amendments

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

B. Termination

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

2022 LEGISLATIVE PROPOSALS

RECEIVED FROM

FLORIDA HEALTH INSURANCE ADVISORY BOARD

(FHIAB) BOARD MEMBERS

FOR DISCUSSION

Louisa McQueeney, Florida Voices for Health

1. Employee/Dependent Option Coverage in Small Group Plans

In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium cost, but spouse/dependent coverage are offered under the plan completely at the employee's expense, with no employer contribution.

Covering a spouse is not mandated by federal law and in the Affordable Care Act (ACA) environment, it would be advantageous to have the option to not offer spousal coverage, so that the spouse could qualify for Premium Tax Credits (PTCs). However, in the group market, carriers do not give small groups the option of not offering spousal coverage.

- ***Recommendation**: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.*

2. Deductible Health Credit Transfer

With the continual rise in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year creates financial hardship. The deductibles for 2022 could end up being as high as $8,700 for an individual and $17,400 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all.

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

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

3. Provide health care consumers with one free copy of their own medical records

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

- ***Recommendation****: Provide consumer with one free copy of their medical record provided to consumer by mail or electronic mail, at the time of payment request for services provided.*

4. Protect Consumers from prescription drug formulary changes during a policy year

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

Consumers enter a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period based on the contract they were presented. Health insurance plans negotiate drug prices with the pharmaceutical companies on behalf of consumers, without any involvement or say of consumers. Insurance carriers then present health plans including drug formularies and premium rates to the Office of Insurance Regulation for approval. The consumer's input is not part of the process; but the consumer is expected to pick up the extra cost in the end or go without the prescription(s) they contracted for.

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

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

5. Prohibit balance billing for emergency medical transportation

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road, water, or air to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but some coverage gaps can leave consumers with surprise high medical bills for the service.

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

6. Include Applied Behavioral Analysis as a covered benefit in all insurance plans

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

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

Once a recipient loses Medicaid eligibility, they lose coverage for these important services. Neither KidCare program policies or exchange and off exchange policies cover ABA services, placing an undue financial burden on families already dealing with very difficult circumstances. Expanding some plans off and on exchange to include coverage for ABA services could provide relief for this population.

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

7. Include Fetal Alcohol Spectrum Disorder (FASD) to the definition of the term developmental disabilities

Harm to Florida's children from prenatal alcohol exposure (PAE) is a significant public health problem and the most known cause of developmental disabilities in the United States. Recent research shows alarming prevalence of up to 1 in 20 first graders in the United States having the resulting disability of Fetal Alcohol Spectrum Disorders (FASD). PAE is especially harmful to the developing brain, impacting all facets of a child's life. Research also shows alcohol causes far greater harm to the brain than other drugs, yet recognition of the disability -- with appropriate FASD informed supports and services -- can prevent secondary disabilities. Among medical and behavioral health professionals, inconsistent use or limited knowledge of diagnostic criteria and clinical guidelines result in many (if not most) children and adults living with FASD going undiagnosed or misdiagnosed. Families struggling with FASD cannot find systems of care that are familiar with or equipped to diagnose and address FASD-related disabilities.

- ***Recommendation****: Include Fetal Alcohol Spectrum Disorder to the definition of the term developmental disabilities in statute 627.6686.*

8. Apply payments by, or on behalf of, a beneficiary to count toward the out-of-pocket cost sharing calculations

Many drug manufacturers offer copay savings programs to help patients afford expensive brand medications as well as specialty drugs. These programs are aimed to provide relief to policyholders who have trouble paying for their prescription drug copays. Most patients, who use copay assistance require highly specialized, life-saving medications to treat hemophilia, MS, HIV, cancer, and other rare and chronic diseases for which, in many cases, no generics are available.

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

Usually the drug companies will provide assistance up to a certain amount per year, so patients mid-year may find out that they have to pay the entire co-pay because none of the third-party payments were counted towards their out-of-pocket. Research has shown that many patients will decline their medication when they have to pay more than $75 to $225 out of pocket foregoing life-saving medication. With the copay accumulator programs, insurers are shifting the cost of prescription drugs to policyholders, making it harder for consumers to meet their deductibles.

The following example explains how the copay accumulator program affects the consumer: A medication costs $20,000 a year for John Doe. With insurance but no copay card John pays $5,000 (deductible) and the insurance company pays $15,000. With a co-pay card John pays $3,500, co-pay card pays $1,500 and the insurance $15,000. With the copay accumulator program John pays $5,000, the co-pay card pays $1,500 and the insurance company pays $13,500. The $1,500 which is supposed to help the consumer is in fact helping the insurer's bottom line.

Various states, including Georgia and West-Virginia, have passed legislation prohibiting Copay Accumulator Programs.

- ***Recommendation****: Require each health insurer, issuing, delivering, or renewing a policy in Florida, which provides prescription drug coverage, administered by the insurer or pharmacy benefit manager, to apply any amount paid by the insured or paid on his or her behalf through a third-party, for which there is no generic drug available, shall be applied toward the policyholder's total contribution to any cost-sharing requirement. Include disclosure in policy documents and on websites, that these payments will be applied to the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.*