The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Rules

BILL:	CS/SB 940
INTRODUCER:	Banking and Insurance Committee and Senators Calatayud and Rodriguez
SUBJECT:	Multiple-employer Welfare Arrangements
DATE:	April 19, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Renner	McKay	CM	**Favorable**
3.	Johnson	Twogood	RC	**Favorable**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 940 revises statutory provisions relating to the regulation of association health plans (AHP), which are a type of multiple employer welfare arrangement (MEWA). A MEWA is a legal arrangement that allows business associations or employer groups to jointly offer health insurance and other specified benefits to their members or employees. In Florida, The Office of Insurance Regulation has regulatory oversight of self-insured MEWAs and AHPs.

In 2018, the U.S. Department of Labor (DOL) revised the Employee Retirement Income Security Act (ERISA) rules by providing another option for establishing and maintaining an association health plan in order to expand access to affordable health coverage for sole proprietors and small employers. This rule loosened the requirements for associations to qualify as ERISA-covered "bona-fide associations," thereby allowing the AHPs they sponsor to qualify as single ERISA plans and be subject to large group market requirements instead of the individual and small group market requirements. Florida codified the 2018 federal regulation defining "bona-fide group." In 2019, the U.S. District Court for the District of Columbia invalidated significant provisions of the federal regulations. The court concluded that the bona fide association and working provisions of the Final Rule are unreasonable and unlawful interpretations of ERISA, and these provisions were vacated by the court.

CS/SB 940 revises the definition of "bona-fide group" under Florida law to include many of the provisions of the 2018 federal rule and removes the cross reference to the 2018 federal

regulation. The bill provides that a bona-fide group is an employee welfare benefit plan consisting of a group or association of member employers that meets the following requirements:

- The primary purpose of the group or association is to offer and provide health coverage to its member employers and their employees, but the group or association must have at least one substantial business purpose that is unrelated to the offering and providing of health insurance. A substantial business purpose is considered to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan.
- Each member employer participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan.
- The group or association has a formal organizational structure with a governing body.
- The functions and activities of the group or association are controlled by its member employers. The control must be present both in form and substance.
- The member employers have a principal place of business in the same region that does not exceed the boundaries of a single state or a metropolitan area, even if the metropolitan area includes more than one state.
- Eligibility for the association or group health coverage offerings is specified, such as an employee or former employee of a current employer member of the group or association; or a beneficiary of the current or former employee.
- The group or association is not a health insurance issuer as described in section 733(b)(2) of ERISA, or owned or controlled by a health insurance issuer or by a subsidiary or affiliate of a health insurance issuer, other than to the extent such entities participate in the group or association in their capacity as member employers of the group or association. This language is substantially similar to language found in 29 C.F.R. part 2510.3-5 (8), with the only difference being the removal of the federal citation for the definition of a health insurance issuer.
- The group or association health coverage must comply with the nondiscrimination provisions of s. 627.6699, F.S., as it applies to small group health plans.

The bill is not expected to have an impact on state or local governments.

The bill takes effect upon becoming law.

II. Present Situation:

Regulation of Multiple Employer Welfare Arrangements under ERISA

The U.S. Department of Labor (DOL) is responsible for the administration and enforcement of the provisions of Title I of the Employee Retirement Income Security Act (ERISA).[1] In general, ERISA prescribes minimum participation, vesting and funding standards for private-sector pension benefit plans and reporting and disclosure, claims procedure, bonding and other requirements which apply to both private-sector pension plans and private-sector welfare benefit plans. ERISA also prescribes standards of fiduciary conduct which apply to persons responsible for the administration and management of the assets of employee benefit plans subject to ERISA.

[1] 29 U.S.C. s. 100 et seq.

ERISA covers only those plans, funds, or arrangements that constitute an "employee welfare benefit plan," as defined in ERISA Section 3(1), or an "employee pension benefit plan," as defined in ERISA Section 3(2). By definition, multiple employer welfare arrangements (MEWAs) do not provide pension benefits; therefore, only those MEWAs that constitute "employee welfare benefit plans" are subject to ERISA's provisions governing employee benefit plans.

Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. On the other hand, if the MEWA was not an ERISA-covered plan, which was generally the case, ERISA's preemption provisions did not apply and states were free to regulate the entity in accordance with applicable state law. In 1983, Congress amended ERISA to give states regulatory authority over self-insured multiple employer welfare arrangements and some regulatory authority over fully insured MEWAs to ensure solvency, require state licensure, and require financial reporting.[2]

Subsequently in 1996, ERISA was amended to give the DOL the authority to require full-insured and self-insured MEWAs to register with the DOL.[3] MEWAs that are not group health plans (non-plan MEWAs) must register with the DOL prior to operating in a state.[4] The purpose of this reporting was to allow the department to determine whether the requirements of part 7 of ERISA were being met.[5] Part 7 of ERISA includes statutory amendments made by HIPAA and other statutes for which MEWAs must annually report compliance.

The Patient Protection and Affordable Care Act[6] (PPACA) created reporting requirements for MEWAs, imposed criminal penalties on MEWA fraud, and authorized the department to take immediate actions against fraudulent MEWAs.

Access to Affordable Health Insurance Coverage through an Association

Prior to August 20, 2018, health insurance coverage offered or provided through an employer trade association, chamber of commerce, or similar organization, to individuals and small employers, was generally regulated under the same federal standards that apply to insurance coverage sold by health insurance issuers[7] directly to these individuals and small employers, unless the coverage sponsored by the group or association constituted a single ERISA covered plan.[8] Generally, unless the arrangement sponsored by the group or association constituted a single ERISA covered plan, the regulatory framework disregarded the group or association in determining whether the coverage obtained by any particular participating individual or

[2] Pub. L. 97-473.
[3] Pub. L. 104-191.
[4] Title 29 CFR s. 2520.101-2.
[5] 65 Fed Reg. 7152 (Feb. 11, 2000) interim rule and 68 Fed. Reg. 17494 (Apr. 9, 2003) final rule.
[6] The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), which amended and revised several provisions of the PPACA, was enacted on March 30, 2010. The laws are collectively referred to as PPACA.
[7] A "health insurance issuer" or ''issuer'' is an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan. 29 CFR 2590.701–2. The terms ''health insurance issuer'' and ''issuer'' are used interchangeably.
[8] Fed. Reg. Vol. 83, No 120 (June 21, 2018) at 28912 and 28913.

employer is individual, small group, or large group market coverage. Instead, the test for determining the type of coverage focuses on whether the coverage is offered to individuals or employers.[9]

As a result, associations that wanted to form association health plans (AHPs) and existing AHPs currently faced a complex and costly compliance environment, insofar as the various employer members of the association and the association's health insurance coverage arrangement may simultaneously be subject to large group, small group, and individual market regulation which undermines one of the core purposes and advantages of an association forming and its employer members joining an AHP.

On June 21, 2018, the DOL issued its final rule on the regulation of AHPs, effective August 20, 2018.[10] The final rule maintains the existing regulatory framework but also creates a second option for both new and existing AHPs that may elect to follow the new regulations. The second option contains the following key provisions:

- Allows for AHPs to be based on a common geography area or a common industry for purposes of the commonality of interest test.
- Allows small employers, including sole proprietors with no employees, to join together to form an AHP and be treated as a large employer for the purpose of buying insurance. Previously an employer with no employees was not eligible for group coverage.
- Includes nondiscrimination protections that prohibit associations from conditioning membership based on a health factor (e.g., health status, medical condition including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability of an employee, or family member). An AHP may not discriminate in eligibility (e.g., enrollment, effective coverage dates, or waiting periods) benefits or premiums against an individual within a group of similarly situated individuals based on health factors. The rule does not prohibit the use of non-health factors such as gender, age, geography, and industry. The rule prohibits groups or associations from treating the employees of different employer members as distinct groups of similarly situated individuals based on a health factor.
- Eliminates the existing requirement that a group or association acting as an employer must exist for purposes other than providing health benefits. The rule requires that a group or association of employers have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members.

The rule provides that states will continue to have regulatory oversight of AHPs and share enforcement authority with the federal government. The new rule does not affect previously existing AHPs, which were authorized under prior guidance.[11] Such plans can continue to operate as before, or elect to follow the new requirements if they want to expand within a geographic area, regardless of industry, or to cover the self-employed. New plans can also form

[9] *Id.* Known as the "look through" doctrine.
[10] 29 CFR Part 2510, *available at* https://www.govinfo.gov/content/pkg/FR-2018-06-21/pdf/2018-12992.pdf (last viewed April 3, 2023).
[11] Fed. Reg. Vol. 83, No. 120 (June 21, 2018) Preamble.

and elect to follow either the old guidance or the new rules. New and existing plans may use experience rating by underwriting premiums for individual employer members based on health status. However, the AHPs that want to do so must continue to meet the prior federal regulations, which are more stringent standards in areas such as commonality of interest; and they could not enroll working owners in an AHP coverage.

In the preamble of the rule, the DOL states that the final rule does nothing to remove the traditional oversight and regulatory authority that states have over AHPs and MEWAs. The final rule does not modify or otherwise limit existing state authority under Section 514 of ERISA. For fully insured AHPs, states can impose solvency standards and other rules that apply to health insurers that sell policies to AHPs. The DOL adds that states clearly have the authority to impose licensing, registration, certification, financial reporting, examination, audit, and any other standards on fully insured AHPs that are necessary to ensure compliance with the state solvency standards. For self-insured AHPs, states can apply insurance laws to the AHP so long as the state law is "not inconsistent" with ERISA.[12]

The rule provides that the large group market's regulatory flexibility is likely to encourage and enable more existing organizations to pursue more potential scale advantages for small business members. These might include some MEWAs that currently do not constitute single large group plans but instead encompass multiple plans, each sponsored separately by a participating employer (non-plan MEWAs).[13] Further, the rule also encourages the establishment of new organizations to sponsor AHPs, and will enable both existing and new AHPs to extend membership to working owners. Fully-insured and self-insured AHPs established under this final rule generally will be subject to federal benefit mandates that apply to the large group insurance and self-insured ERISA-covered markets, respectively.

Federal Litigation Relating to the Regulations of AHPs

Eleven states and the District of Columbia sued the DOL alleging that its final rule interpreting the definition of "employer" in ERISA is unlawful under the Administrative Procedure Act.[14] The court held that the bona fide association and working owner provisions of the final rule, codified at 29 C.F.R. ss. 2510.3-5(b), (c), and (e), are unreasonable interpretations of ERISA and were vacated by the court.[15] The court concluded that the final rule was intended to end run the requirements of PPACA.[16] The court notes that the final rule includes a severability provision, which provides that if a provision is found entirely invalid then "the provision shall be severable from (the final rule) and shall not affect the remainder thereof." In light of this provision, the court remanded the final rule to the agency for consideration in the first instance of how the

[12] Section 514(b)(6)(A)(ii) of ERISA. *See* Health Affairs Blog, *Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans* (June 21, 2018), available at https://www.healthaffairs.org/do/10.1377/forefront.20180621.671483/full/ (last visited April 3, 2023).
[13] Health Affairs Blog, *Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans* (June 21, 2018), *available at* https://www.healthaffairs.org/do/10.1377/forefront.20180621.671483/full/ (last visited April 3, 2023).
[14] *State of New York, et al., v. United States Department of Labor*, 363 F.Supp.3d 109 (D.C. Cir 2019).
[15] *Id.* at 141.
[16] *Id.*

severability provision affects the remaining portions of the final rule. The Department of Justice appealed the court's decision to the court of Appeals for the District of Columbia.[17]

On April 29, 2019, the DOL provided guidance[18] regarding their enforcement stance for AHPs created under the new rule. The court ruling was issued days before the rule went fully into effect for new self-insured AHPs.[19] Because the rule had already been partially in effect, there were questions about what the court's decision meant for consumers who already enrolled in new AHP coverage.[20]

Under this guidance, the DOL and HHS stated that they would not take enforcement action for violations that occurred before court decision so long as the entity made those decisions in good faith reliance on the validity of the AHP rule.[21] DOL will not take action against existing AHPs for continuing to provide benefits to members who enrolled in good faith reliance on the AHP rule's validity before the district court's order, through the remainder of the applicable contract term. Further, at the end of the plan year, the issuer would only be able to renew the coverage for an employer member of an AHP formed pursuant to the DOL's final rule if the coverage complies with the relevant market requirements for that employer's size (such as, for insurance sold to small employers, the essential health benefits requirements and premium rating rules). The guidance provided that an insurer can satisfy the requirement to continue the coverage in force by continuing coverage for each employer-member of the association that chooses to continue coverage, either through the master policy with the association or through separate contracts with each employer-member on an outside-the-association basis.

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[22] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S., and before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[23]

Regulation of Multiple Employer Welfare Arrangements—General Provisions

Section 627.651, F.S., provides that group health insurance contracts and plans of self-insurance must meet certain group requirements. Further, this section does not apply to any plan which is established or maintained by an individual employer in accordance with ERISA or to a MEWA, as defined in s. 624.437, F.S., except that a MEWA must comply with the following statutory provisions:

[17] Health Affairs Blog, *DOL Issues Additional Guidance On AHPs* (May 15, 2019), *available at* https://www.healthaffairs.org/do/10.1377/forefront.20190515.142866/full/ (last visited April 3, 2023).
[18] U.S. Department of Labor Statement Relating to the U.S. District Court Ruling in State of New York v. United States Department of Labor | U.S. Department of Labor (dol.gov) (Apr. 29, 2019) (last visited April 3, 2023).
[19] DOJ Appeals AHP Decision, CMS Posts Final 1332 Funding For 2019 | Health Affairs (Apr. 30, 2019).
[20] *Supra* note 17.
[21] *Supra* note 18.
[22] Section 20.121(3)(a), F.S.
[23] Section 641.21(1), F.S.

- 627.419, F.S., relating to the construction of policies.
- 627.657, F.S., relating to guaranteed availability of individual health insurance coverage.
- 627.6575, F.S., relating to group coverage for newborn children.
- 627.6578, F.S., relating to group coverage for natural-born, adopted, and foster children; and children in insured's custodial care.
- 627.6579, F.S., relating to group coverage for child health supervision services.
- 627.6612, F.S., relating to group coverage for surgical procedures and devices incident to mastectomy.
- 627.66121, F.S., relating to coverage length of stay and outpatient postsurgical care for breast cancer.
- 627.66122, F.S., relating to group coverage for breast cancer and routine follow up care.
- 627.6615, F.S., relating to group coverage continuation of coverage for children with disabilities.
- 627.6616, F.S., relating to group coverage for ambulatory surgical center service.
- 627.662(7), F.S., relating to denial of claims.[24]

Florida's Nonprofit Multiple Employer Welfare Arrangement Act

In Florida, MEWAs[25] are regulated pursuant to the Florida's Nonprofit Multiple Employer Welfare Arrangement Act (act).[26] An AHP consisting of multiple employers is referred to as a MEWA.[27] For purposes of this act, a MEWA is an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, F.S., other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries.[28] A person may not operate, maintain, or, after October 1, 1983, establish a MEWA unless such arrangement has a valid certificate of authority issued by the OIR.[29]

The OIR uses the requirements of s. 624.438, F.S., to determine eligibility for MEWAs[30] and specifies the application requirements in Rule 69O-192.008, F.A.C. The OIR reviews MEWA

[24] Section 627.645(1), F.S. provides that a claim for payment under a health insurance policy or self-insured program of health benefits for treatment, care, or services in a licensed hospital that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state may not be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.
[25] Section 624.437(3), F.S., provides this section does not apply to a MEWA that offers or provides fully insured benefits by an authorized insurer, to an arrangement which is exempt from state insurance regulation pursuant to ERISA, or to the state group insurance program.
[26] Section 624.436-624.448, F.S. which may be cited as the "Florida Nonprofit Multiple Welfare Arrangement Act."
[27] Section 624.438, F.S.
[28] Section 624.437(1), F.S. Subsection (3) of this section exempts a MEWA that offers or provides benefits which are fully insured by an authorized insurer, to an arrangement which is exempt from state insurance regulation in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), and the state group health insurance program administered pursuant to s.110.123, F.S.
[29] Section 624.437(2), F.S.
[30] *See* Office of Insurance Regulation, *2023 Legislative Session, SB 940 Analysis* (Feb. 22, 2023). On file with the Senate Banking and Insurance Committee.

applications for compliance with Florida law and does not review for compliance with federal standards.[31]

In 2019, s. 624.438, F.S., was amended to codify the cross reference to the definition of bona fide group, as adopted in the 2018 federal rule. This change also was made in s. 627.654, F.S, relating to labor unions, association of employers, and small employer alliance groups.[32] Section 624.438, F.S., specifies the general eligibility criteria for a MEWA and requires the employers to be in the same trade, industry, or profession as defined by the appropriate licensing agencies, or a bona fide group as defined in 29 C.F.R. part 2510.3-5. It also requires the MEWA to have a constitution or bylaws specifically stating its purpose and which has been organized for purposes in addition to obtaining or providing insurance.

In Florida, three MEWAs are licensed by Office of Insurance Regulation. They are the Florida Bankers Health Consortium, Inc., Greater Health Trust, and Independent Colleges and Universities Benefit Association, Inc.[33]

Labor Unions, Association, and Small Employer Health Alliance Groups

Section 627.654, F.S., provides that a bona fide group or association or association of employers, as defined in 29 C.F.R. part 2510.3-5, or a group of individuals insured under an association may include a labor union or small employer health alliance groups if certain conditions are met.

Regulation of Small Group Employers

Section 627.6699, F.S., the Employee Health Care Access Act, defines a small group as an employer with at least one and not more 50 employees. The act provides restrictions relating to premium rates. The act allows the use of modified community rating in which the premium for each small employer is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area. In addition, premium adjustments of an employer's rate for claims experience, health status, or duration of coverage may deviate plus or minus 15 percent from the carrier's approved rate.[34] Subsequently, a small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually due to claims experience, health status, or duration of coverage of the employees or dependents of the small employer.

The rating and underwriting standards of PPACA[35] require that premiums for individuals and small groups may vary only by:

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[31] *Id.* The OIR states that the U.S. Department of Labor advisory opinion and the 2018 Federal District Court opinion do not impact OIR's review of MEWA licensing applications.
[32] Ch. 2019-129, Laws of Fla. Section 627.654, F.S., provides eligibility requirements for associations, labor unions, and small employer health alliance groups that want to be insured under a policy issued to their respective entity.
[33] Office of Insurance Regulation, Company Search (myfloridacfo.gov) (last visited April 3, 2023)
[34] Section 627.6699(6), F.S.
[35] PPACA requires individual and small group plans to provide certain essential benefits and creates rating standards. PPACA preempts any state law that prevents the application of a provision of the PPACA. The PPACA effectively allows states to adopt and enforce laws that provide greater consumer protections than the PPACA, but any state law that does not meet the federal minimum standards will be preempted. Pub. L. No. 111–148, s. 1321(d).

- Age, up to a maximum ratio of 3 to 1. This means rates for older adults may not be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.[36]

III. Effect of Proposed Changes:

Section 1. Amends s. 624.438, F.S., by deleting the current definition of "bona fide group," which is defined by a cross reference to the 2018 federal rule, 29 C.F.R. 2510-3-5. The definition of the term, "bona fide group" is created within the section and it is similar but not identical to the federal definition and requirements. The bill provides that a bona fide group that is an employee welfare benefit plan includes a group or association which meets the following requirements:

- The primary purpose of the group or association is to offer and provide health coverage to its member employers and their employees, but the group or association has at least one substantial business purpose that is unrelated to the offering and providing of health insurance. A substantial business purpose is considered to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan.
- Each member employer participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan.
- The group or association must have a formal organizational structure with a governing body.
- The functions and activities of the group or association are controlled by its member employers. The control must be present both in form and substance.
- The member employers must have a principal place of business in the same region that does not exceed the boundaries of a single state or a metropolitan area, even if the metropolitan area includes more than one state.
- Eligibility for health coverage offered by the individuals and employers of the association or group is specified.
- The group or association health coverage must comply with the nondiscrimination provisions of section 627.6699, F.S., as it applies to small group health plans rather than the federal requirements.[37] Section 627.6699, F.S. allows for the use of modified community rating in which the premium for each small employer is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area. In addition, premium adjustments of plus or minus 15 percent of the approved rate are allowed for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. The federal rule does not provide rating bands. Section 627.654, F.S., provides that a small employer, as defined in s. 627.6699, F.S., may be insured under a policy issued to a small employer health alliance by a carrier, as defined in s. 627.6699, F.S.
- Specifies that the group or association is not a health insurance issuer as described in section 733(b)(2) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1191b(b)(2), or owned or controlled by a health insurance issuer or by a subsidiary or

[36] 42 U.S.C. s.18022.
[37] *Supra* note 9.

affiliate of a health insurance issuer, other than to the extent such entities participate in the group or association in their capacity as member employers of the group or association.

Section 2. Amends s. 627.654, F.S., to provide that a bona fide group, as defined in s. 624.438(1)(b)4., F.S., an association of employers, or a group of individuals may be insured under an association, including a labor union, if certain conditions are met. The reference to the federal rule, 29 C.F.R. part 2510.3-5, that defines a bona-fide group is removed and replaced with a reference to the definition created in ss. 624.438(1)(b)4., F.S.

Section 3. Provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Implementation of the bill will clarify the regulations of self-funded MEWAs in Florida.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Under federal law, self-employed employers or sole proprietors that have no employees are generally not eligible for group coverage. Instead, they may obtain coverage in the individual market.[38] It is unclear whether such employers would qualify as an employee of a current group member under Florida law.[39]

VIII. Statutes Affected:

This bill substantially amends sections 624.438 and 627.654 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 29, 2023:
The amendment makes technical and conforming changes.

B. Amendments:

None.

[38] 45 CFR s. 155.20.
[39] *See* Office of Insurance Regulation, *2023 Legislative Session, SB 940 Analysis* (Feb. 22, 2023). On file with Senate Committee on Banking and Insurance.