Bill No. CS for SB 2516

Amendment No. ___

CHAMBER ACTION

| Senate | House |
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Senator Meek moved the following amendment:

**Senate Amendment (with title amendment)**

On page 10, between lines 26 and 27,

insert:

Section 10. Subsections (1), (6), (7), and (8) of section 627.410, Florida Statutes, 1998 Supplement, are amended to read:

627.410 Filing, approval of forms.--

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department. This provision does not apply to:

(a) Surety bonds or to specially rated inland marine

risks, or

(b) Policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to individual or small group health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the department for information purposes only.

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the department a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the department applicable premium rates and any change in applicable premium rates. This provision does not apply to rating manuals, rating schedules, changes in rating manuals or schedules, or if rating manuals or schedules are not applicable, to premium rates or changes in such rates, relating to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject or to benefits under group health insurance policies insuring 51 or more persons and are used at the request of the individual policyholder, contract holder, or certificate holder.

(b) The department may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) ~~Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless~~

~~the insurer has actively offered it for sale in the previous 12 months.~~

1. An insurer may discontinue the availability of a policy form if the insurer provides to the department in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the department, the insurer shall no longer offer for sale the policy form or certificate form in this state.

~~2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the department of the discontinuance. The period of discontinuance may be reduced if the department determines that a shorter period is appropriate.~~

2.~~3.~~ The experience of an individual accident and health insurance ~~all~~ policy form that is no longer being marketed in this state, except for policies rated pursuant to a loss ratio guarantee under subsection (8), shall be combined with the experience of at least one other individual accident and health insurance policy form ~~forms~~ providing similar benefits, as determined by the insurer, which is still being marketed in the state by the same insurer, unless the insurer has no other policy form providing similar benefits, as determined by the insurer, which is still being marketed in the state ~~shall be combined for all rating purposes~~.

3. Each individual accident and health insurer that discontinues the availability of a policy form and that has no other policy form providing similar benefits which is still being marketed in the state shall offer every existing insured

who is currently paying premiums under the discontinued policy form the option to apply for coverage under any individual accident and health insurance policy form which is still being marketed in the state by the same insurer. Individuals who fail to satisfy the insurer's underwriting guidelines or standards for issuance of a replacement policy shall be issued coverage if they apply for such replacement coverage within 180 days' written notice to the insured persons from the insurer, without regard to health status or claims experience. However, individuals who apply for the replacement coverage described in this subparagraph who fail to satisfy the insurer's underwriting guidelines or standards may be charged a premium rate not to exceed 140 percent of the standard premium rate charged by the insurer for the coverage. The replacement coverage described in this subparagraph shall waive any preexisting condition limitations or waiting periods satisfied under the preceding, discontinued policy form.

4. For purposes of this paragraph an individual accident and health insurance policy form shall be deemed to provide similar benefits to another individual accident and health insurance policy form if the forms are of the same type, e.g. major medical; hospital/surgical; disability; home health care; long-term care, and at least 70 percent of the benefits provided by one form are also provided by the other.

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the department no later than 12 months after its previous filing, establishing ~~demonstrating~~ the reasonableness of benefits in relation to premium rates. The department, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies

in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(b) The filing required by this subsection shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation establishing ~~demonstrating~~ the reasonableness of benefits in relation to premiums charged ~~in accordance with the applicable rating laws and rules promulgated by the department~~. For premium rate changes, benefits shall be deemed reasonable in relation to premium charged if both of the following loss ratios meet or exceed the standards established in s. 627.411(2).

a. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage; and

b. The lifetime anticipated loss ratio derived by dividing the amount determined under sub-sub-subparagraph (I) by the amount determined under sub-sub-subparagraph (II):

(I) The sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits.

(II) The sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums, which present values shall be taken over the entire period for which the revised rates are computed to provide coverage and which accumulated benefits and premiums shall include an explicit estimate of actual benefits and premiums from the last date an accounting has been made to the effective date of the revision.

Interest shall be used in the calculation of these accumulated benefits and premiums and present values in the calculation of the loss ratio. For purposes of sub-sub-subparagraph (I), the present value of benefits may, at the insurer's option, include recognition of the policy reserve as a benefit (addition), or the present value of premiums may, at the insurer's option, include recognition of the policy reserve as a deduction. Anticipated loss ratios lower than those indicated in sub-sub-subparagraphs (I) and (II) will require justification based on special circumstances that may be applicable. Examples of coverages that may require special consideration are accident only, short-term nonrenewable, specified peril, and other special risks. Examples of other factors that may require special consideration are marketing methods; giving due consideration to acquistion and administration costs and premium mode; extraordinary expenses; high risk of claims fluctuation because of low loss frequency or the catastrophic or experimental nature of the coverage; product features such as long elimination periods, high deductibles, and high maximum limits; and the industrial or debit method of distribution.

2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with the loss ratio standards established in this section and s. 627.411(2)~~applicable laws and rules promulgated by the department~~.

(c) As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not

employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the department for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the department in its offices in Tallahassee no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the department may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the department determines that the required filing is properly submitted.

(8)(a) For the purposes of subsections (6) and (7) and s. 627.411, benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, ~~when authorized by rules adopted by the department~~, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to comply with the provisions cited in this section ~~to be reasonable in relation to premium rates~~ if the rates are filed pursuant to a loss

ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the department, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The department shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the department may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.

(b) The renewal premium rates shall be deemed to be approved upon filing with the department if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:

1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.

2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.

3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the department no later than the end of such quarter. The department shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.

4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period

for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the department has adequate time to review the report.

5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the department, shall withdraw the policy form for the purposes of issuing new policies.

(c) As used in this subsection:

1. "Loss ratio" means the ratio of incurred claims to earned premium.

2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio; however, if there are less than 2,000 policyholder years nationwide, the experience must be accumulated until the end of the calendar year in which 2,000 policyholder years are obtained.

3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

(d) The department shall not disapprove or withdraw any previous approval of any individual accident and health insurance form pursuant to s. 627.411(1)(e) if rates have been

filed as provided in this subsection.

Section 11. Section 627.411, Florida Statutes, is amended to read:

627.411 ~~Grounds for~~ Disapproval of forms.--

(1) The department shall disapprove any insurance policy form that must be filed under s. 627.410, or withdraw any previous approval thereof, only if the form:

(a) Is in any respect in violation of, or does not comply with, this code.

(b) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(c) Has any title, heading, or other indication of its provisions which is misleading.

(d) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(e)1. Is for health insurance, and provides benefits which are unreasonable in relation to the premium charged; or~~,~~

2. Contains provisions that constitute unfair discrimination pursuant to s. 626.9541(1)(g),~~which are unfair or inequitable as contrary to the public policy of this state~~ or which encourages misrepresentation ~~or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices~~.

(f) Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or

conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(2) ~~In determining whether the~~ Benefits are deemed reasonable in relation to the premium charged if premium rates are neither excessive nor inadequate.~~, the department, in accordance with reasonable actuarial techniques, shall consider:~~

~~(a) Past loss experience and prospective loss experience within and without this state.~~

~~(b) Allocation of expenses.~~

~~(c) Risk and contingency margins, along with justification of such margins.~~

~~(d) Acquisition costs.~~

(a) Premium rates are not excessive if the insurer demonstrates, in accordance with generally accepted standards of actuarial practice, satisfaction of the following minimum anticipated loss ratios.

1. Loss Ratio Table, Individual Policies for the Line of Business Indicated.--

a. Medical Expenses.--

| Renewal Clause | Loss Ratio |
|---|---|
| Noncancelable | 55 percent |
| Nonrenewable | 60 percent |
| Guaranteed Renewable | 65 percent |
| All others | 70 percent |

b. Medical Indemnity, Loss of Income.--

| Renewal Clause | Loss Ratio |
|---|---|
| Noncancelable | 50 percent |
| Nonrenewable | 55 percent |

| | |
|---|---|
| Guaranteed Renewable | 60 percent |
| All others | 65 percent |

2. Loss Ratio Table, Group Policies.--

a. Group Medical Expense.--

| Group Size | Loss Ratio |
|---|---|
| Fewer than 51 certificates | 65 percent |
| 51 through 500 certificates | 70 percent |
| All others | 75 percent |

b. Group Medical Indemnity or Any Group Policy with and Average Annual Premium per Certificate of Less Than $1,000.--

| Group Size | Loss Ratio |
|---|---|
| Fewer than 51 certificates | 57.5 percent |
| 51 through 500 certificates | 62.5 percent |
| All others | 67.5 percent |

3. Group conversion insurance, other than long-term-care insurance and Medicare supplement insurance, issued on either a group or an individual basis, shall have a loss ratio of not less than 120 percent, subject to the limits described in s. 627.6675.

4. The lifetime loss ratios in subparagraphs 1. and 2. may be adjusted in accordance with the following formula:

R' = (A - 25I) R/A

where:
R = the loss ratio from subparagraphs 1. and 2.;
A = the average annualized premium per individual policy or per group certificate;
I = (CPI-U, year N-1)/103.9;
R' = the adjusted loss ratio.

R' cannot be more than 10 percentage points less than R nor less than 50 percent, except that R' cannot be less than 45 percent as to accident only non-cancellable policies. The CPI-U is the consumer price index for all urban consumers, for all items and for all regions of the U. S. combined, as determined by the U. S. Department of Labor, Bureau of Statistics as of September of each year. Year N-1 is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in Florida.

5. Blanket insurance is exempt from the loss ratios described in subparagraphs 1.-3. The minimum loss ratio for blanket insurance is 65 percent.

6. Medicare supplement and long-term-care insurance are exempt from the loss ratios described in subparagraphs 1.-3. The minimum loss ratios for Medicare supplement insurance must be established in accordance with s. 627.674. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In determining the expected loss ratio, the Insurance Department shall adopt rules consistent with the Long-Term Care Model Regulation as approved by the National Association of Insurance Commissioners in July 1998.

(b) Premium rates are not inadequate if the insurer demonstrates, in accordance with generally accepted standards of actuarial practice, that the sum of premium income and investment income, minus the sum of benefit payments, expenses, taxes, and contingency margins is greater than zero.

Section 12. Subsection (6) is added to section

626.883, Florida Statutes, to read:

626.883 Administrator as intermediary; collections held in fiduciary capacity; establishment of account; disbursement; payments on behalf of insurer.--

(6) All payments to a health care provider by a fiscal intermediary for noncapitated providers must include an explanation of services being reimbursed which includes, at a minimum, the patient's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is being made. For capitated providers, the statement of services must include the number of patients covered by the contract, the rate per patient, the total amount of the payment, and the identification of the plan on whose behalf the payment is being made.

Section 13. Paragraph (a) of subsection (2) of section 641.316, Florida Statutes, 1998 Supplement, is amended to read:

641.316 Fiscal intermediary services.--

(2)(a) The term "fiduciary" or "fiscal intermediary services" means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations. All payments to a health care provider by a fiscal intermediary for noncapitated providers must include an explanation of services being reimbursed which includes, at a minimum, the patient's name, the date of service, the procedure code, the amount of

reimbursement, and the identification of the plan on whose behalf the payment is being made. For capitated providers, the statement of services must include the number of patients covered by the contract, the rate per patient, the total amount of the payment, and the identification of the plan on whose behalf the payment is being made.

(Redesignate subsequent sections.)

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

On page 1, line 2, delete that line

and insert:

An act relating to health insurance; amending s. 627.410, F.S.; modifying rate filing requirements for approval of health insurance policy forms by the Department of Insurance; amending s. 627.411, F.S.; providing guidelines for determining when benefits are considered reasonable in relation to the premium charged for purposes of disapproval of health insurance policy forms by the department; amending s. 626.883, F.S.; relating to payments on behalf of insurer; amending s. 641.316, F.S.; relating to payments to a health care provider; amending s.