By Senator Forman

32-812A-00

A bill to be entitled

An act relating to health care coverage; amending s. 627.402, F.S.; defining the term "insurer conduct"; amending s. 627.410, F.S.; prescribing requirements for determining whether a health insurance policy provides benefits that are reasonable in relation to premium rates; providing disclosure requirements regarding rates; revising certain filing requirements regarding actuarial justification; deleting certain provisions that establish presumptions regarding the reasonableness of rates; amending s. 627.411, F.S.; authorizing the Department of Insurance to disapprove forms, rate manuals, or rate schedules because of certain rates or rate increases; creating s. 627.42396, F.S.; requiring certain health insurance policies to allow insureds to obtain drugs that are not included in the insurer's drug formulary; amending s. 641.31, F.S.; providing requirements for determining whether a health maintenance contract provides benefits that are reasonable in relation to premium rates; providing disclosure requirements regarding premium rates; authorizing the Department of Insurance to disapprove rate changes that exceed certain standards; requiring certain health maintenance contracts to allow members to obtain drugs that are not included in the health maintenance organization's drug

formulary; amending s. 641.315, F.S.; prohibiting certain referrals to collection agencies; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) is added to section 627.402, Florida Statutes, to read:

627.402 Definitions; specified certificates not included.--As used in this part, the term:

(3) "Insurer conduct" means the following actions or inactions of an insurer or health maintenance organization with respect to a policy form which result in inadequate rates and the need for extraordinary rate increases:

(a) Failure to make a filing in compliance with s. 627.410(7) or s. 627.6745(2);

(b) Failure to correct a rate filing when the department has presented information to the company at the time the filing is approved which suggests that the rates are inadequate and the company fails to adequately resolve the department's concerns;

(c) Violation of applicable actuarial standards of practice at the time of a filing;

(d) Failure to implement the underwriting standards assumed in the pricing assumptions of the form; or

(e) The use of pricing assumptions that demonstrate a pattern of product underpricing.

Section 2. Subsections (6), (7), and (8) of section 627.410, Florida Statutes, are amended to read:

627.410 Filing, approval of forms.--

(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.

(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.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

(f) To satisfy the requirement that benefits are reasonable in relationship to the premium rates, in addition to any requirement established under paragraph (b), the premium rate schedule must:

1. Reflect only the actual and reasonable administrative expenses of the insurer for the efficient administration and maintenance of the affected forms;

2. Reflect a reasonable profit and contingency margin; and

3. For coverage sold to an individual who pays up to a stated predetermined amount per day or per confinement for one or more named conditions, named diseases, or accidental injury, or pays based on the costs of specified health care services, be determined such that not less than 85 percent of additional premiums charged an insured, which premiums are charged at greater than the rate in effect when the coverage was purchased, will apply to policyholder benefits. This subparagraph does not apply to increases in premiums for attained age based on an existing premium rate schedule, nor to policies for which 30 percent or more of the total initial health insurance claim costs are attributable to benefits that are based on costs of specified health care services.

(g) Each insurer shall provide the following disclosure information to potential insureds at the time of solicitation of coverage and to all insureds at the time of any rate increase under the form in readily understandable language and format. The disclosure must include the current rate and any scheduled or anticipated rate increases, an explanation of when the rates may be changed, and a 10-year rate increase history on the form and similar forms. The information must be filed with the department with any form or rate filing made under this section. The department may adopt rules to administer this paragraph.

(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, 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 demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the department.

2. If no rate change is proposed, a filing that ~~which~~ consists of actuarial justification and a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with procedures that are consistent with applicable laws and rules adopted ~~promulgated~~ by the department.

(c) As used in this section, "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), 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 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.~~

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

Section 3. Subsection (1) of section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.--

(1) The department may ~~shall~~ disapprove any form, rate manual, or rate schedule filed under s. 627.410, or withdraw any previous approval thereof, only if the form, manual, or schedule:

(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) Is for health insurance, and provides benefits that ~~which~~ are unreasonable in relation to the premium charged or~~,~~contains provisions that ~~which~~ are unfair or inequitable~~,~~ ~~or~~ are contrary to the public policy of this state~~,~~ are unfairly discriminatory~~,~~ ~~or which~~ encourage misrepresentation, or ~~which~~ apply rating methods, assumptions, or practices that result in:

1. Rate increases because of insurer conduct as defined in s. 627.402, unless such increase is implemented with an approved rate for new insureds and as to existing insureds at the time of the increase, over a period of years as follows:

a. For forms with benefits subject to medical inflation, the premium schedule increase applicable to existing insureds at the time of the filing must be the greater of 10 percent or 135 percent of medical trend. Annual rate increases in subsequent years for the new issue premium schedule must be increased in accordance with rules adopted by the department. The annual increase for the existing insureds, premium schedule must be the greater of 10 percent of the new issue premium schedule or 135 percent of the rate increase approved for the new issue premium schedule until the two premium schedules converge.

b. For forms with benefits not subject to medical inflation, the period of years for the two schedules to converge must be 2 years if the two rate increases are less than 10 percent, otherwise 3 years;

2. Rate increases because of multiple events of insurer conduct unless a plan of corrective action is approved by the department;

3. Rate increases attributed to forms being closed to new sales, unless such increase is limited to the rate increase being realized in the general insurance market of current forms available for sale with similar benefits; or

4. For new forms, rate schedules that are not actuarially sustainable, except for medical-trend increases where applicable.

The department shall adopt rules to implement this paragraph. ~~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.

Section 4. Section 627.42396, Florida Statutes, is created to read:

627.42396 Coverage for prescription drugs.--A health insurance policy that offers prescription drug coverage for drugs included in a formulary must also contain a provision that allows insureds to obtain prescription drugs not included in the insurer's drug formulary, if the insured's treating physician certifies that the drug is essential for effective treatment of the insured's covered condition. The insured's

copayment may not exceed the amount payable by the insured for nongeneric prescription drugs covered by the formulary.

Section 5. Subsections (1), (2), and (3) of section 641.31, Florida Statutes, are amended and subsection (39) is added to that section to read:

641.31 Health maintenance contracts.--

(1) Any entity issued a certificate and otherwise in compliance with this part may enter into contracts in this state to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum. Each subscriber shall be given a copy of the applicable health maintenance contract, certificate, or member handbook. Whichever document is provided to a subscriber shall contain all of the provisions and disclosures required by this section.

(2)(a) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The department, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(b) To satisfy the requirement that benefits are reasonable in relationship to the rates charged, in addition to any requirement established under paragraph (a), the premium rate schedule must:

1. Reflect only the actual and reasonable administrative expenses of the health maintenance organization for the efficient administration and maintenance of the affected forms; and

2. Demonstrate a reasonable profit and contingency margin.

(c) Each health maintenance organization shall provide the following disclosure information to potential subscribers at the time of solicitation of coverage and to all subscribers at the time of any rate increase under the form in readily understandable language and format. The disclosure must include the current rate and any scheduled or anticipated rate increases, an explanation of when the rates may be changed, and a 10-year rate increase history on the form and similar forms. The information must be filed with the department with any form or rate filing made under this section. The department may adopt rules to administer this paragraph.

(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the department the proposed change or amendment. Any proposed change shall be effective immediately, subject to disapproval by the department. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or

use any form disapproved by the department or as to which the department has withdrawn approval.

(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.

(c) The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. 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.

3. Has any title, heading, or other indication of its provisions which is misleading.

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

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. 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.

(d)1. Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the department. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved.

2. The department shall disapprove any change in rates which applies rating methods, assumptions, or practices that result in:

a. Rate increases because of insurer conduct, as defined in s. 627.402, unless such increase is implemented with an approved rate for new insureds and as to existing insureds at the time of the increase, over a period of years, so that for forms with benefits subject to medical inflation, the premium schedule increase applicable to existing insureds at the time of the filing is the greater of 10 percent or 135 percent of medical trend. Annual rate increases in subsequent years for the new issue premium schedule must be increased in accordance with rules adopted by the department. The annual

increase for the existing insureds' premium schedule must be the greater of 10 percent of the new issue premium schedule or 135 percent of the rate increase approved for the new issue premium schedule until the two premium schedules converge;

b. Rate increases because of multiple events of insurer conduct unless a plan of corrective action is approved by the department;

c. Rate increases attributed to forms being closed to new sales, unless such increase is limited to the rate increase being realized in the general insurance market of current forms available for sale with similar benefits; or

d. For new forms, rate schedules that are not actuarially sustainable, except for medical-trend increases where applicable.

The department shall adopt rules to implement this subparagraph.

(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(39) A health maintenance organization contract form that provides prescription drug coverage for drugs included in a formulary must also contain a provision that allows members to obtain prescription drugs not included in the health maintenance organization's drug formulary if the member's treating physician certifies that the drug is essential for effective treatment of the member's covered condition. The member's copayment may not exceed the amount payable by the member for nongeneric prescription drugs covered by the formulary.

Section 6. Subsection (3) of section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(3) No provider of services or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO, including referral to a collection agency, and no provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

Section 7. This act shall take effect July 1, 2000, and apply to all policies, contracts, and policies issued or renewed on or after that date.

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SENATE SUMMARY

Revises numerous provisions relating to rates and rate increases on health insurance policies and health maintenance contracts. Establishes disclosure requirements and provides rate increase guidelines. Authorizes the Department of Insurance to disapprove certain forms, rate manuals, and rate schedules. Provides for insureds and members to obtain non-formulary drugs. Defines the term "insurer conduct." Prohibits HMO's from referring certain debts to collection agencies. (See bill for details.)