By the Committee on Banking and Insurance; and Senator Latvala

311-1563-01

A bill to be entitled

An act relating to health insurance; amending s. 627.410, F.S.; requiring certain group certificates for health insurance coverage to be subject to the requirements for individual health insurance policies; exempting group health insurance policies insuring groups of a certain size from rate filing requirements; providing alternative rate filing requirements for insurers with less than a specified number of nationwide policyholders or members; amending s. 627.411, F.S.; revising the grounds for the disapproval of insurance policy forms; providing that a health insurance policy form may be disapproved if it results in certain rate increases; specifying allowable new business rates and renewal rates if rate increases exceed certain levels; authorizing the Department of Insurance to determine medical trend for purposes of approving rate filings; amending s. 627.6487, F.S.; revising the types of policies that individual health insurers must offer to persons eligible for guaranteed individual health insurance coverage; prohibiting individual health insurers from applying discriminatory underwriting or rating practices to eligible individuals; amending s. 627.6515, F.S.; requiring that coverage issued to a state resident under certain group health insurance policies issued outside the state be subject to

the requirements for individual health insurance policies; amending s. 627.6699, F.S.; revising definitions used in the Employee Health Care Access Act; allowing carriers to separate the experience of small employer groups with fewer than two employees; revising the rating factors that may be used by small employer carriers; amending s. 627.6741, F.S.; requiring that insurers offer Medicare supplement policies to certain individuals; amending s. 627.9408, F.S.; authorizing the department to adopt by rule certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners; amending s. 641.31, F.S.; exempting contracts of group health maintenance organizations covering a specified number of persons from the requirements of filing with the department; specifying the standards for department approval and disapproval of a change in rates by a health maintenance organization; providing alternative rate filing requirements for organizations with less than a specified number of subscribers; providing an effective date.

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

Section 1. Subsection (1) and paragraph (a) of subsection (6) of section 627.410, Florida Statutes, are

amended, and paragraph (f) is added to subsection (7) of that section, 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 surety bonds or to 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 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, except that group certificates for health insurance coverage, as described in s. 627.6561(5)(a)2., which require individual underwriting to determine coverage eligibility or premium rates to be charged, shall be considered policies issued on an individual basis and are subject to and must comply with the Florida

Insurance Code in the same manner as individual health insurance policies issued in this state.

(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 paragraph does not apply to group health insurance policies insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(7)

(f) Insurers with fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms with health insurance coverage, as described in s. 627.6561(5)(a)2., excluding Medicare supplement insurance coverage under part VIII, at the time of a rate filing made pursuant to subparagraph (b)1., may file for an annual rate increase limited to medical trend as adopted by the department pursuant to s. 627.411(4). The filing is in lieu of the actuarial memorandum required for a rate filing prescribed by paragraph (6)(b). The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 2. Section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.--

(1) The department shall disapprove any form 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) Is for health insurance, and:

1. Provides benefits that ~~which~~ are unreasonable in relation to the premium charged;~~,~~

2. Contains provisions that ~~which~~ are unfair or inequitable or contrary to the public policy of this state or that ~~which~~ encourage misrepresentation;~~, or~~

3. Contains provisions that ~~which~~ apply rating practices that ~~which result in premium escalations that are not viable for the policyholder market or~~ result in unfair discrimination pursuant to s. 626.9541(1)(g)2.;~~in sales practices.~~

4. Results in actuarially justified rate increases on an annual basis:

a. Attributed to the insurer reducing the portion of the premium used to pay claims from the loss ratio standard

certified in the last actuarial certification filed by the insurer, in excess of the greater of 50 percent of annual medical trend or 5 percent. At its option, the insurer may file for approval of an actuarially justified new business rate schedule for new insureds and a rate increase for existing insureds that is equal to the greater of 150 percent of annual medical trend or 10 percent. Future annual rate increases for existing insureds shall be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge;

b. In excess of the greater of 150 percent of annual medical trend or 10 percent and the company did not comply with the annual filing requirements of s. 627.410(7) or department rule for health maintenance organizations pursuant to s. 641.31. At its option the insurer may file for approval of an actuarially justified new business rate schedule for new insureds and a rate increase for existing insureds that is equal to the rate increase allowed by the preceding sentence. Future annual rate increases for existing insureds shall be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge; or

c. In excess of the greater of 150 percent of annual medical trend or 10 percent on a form or block of pooled forms in which no form is currently available for sale.

(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 reasonable in relation to the premium charged, 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.

(3) If a health insurance rate filing changes the established rate relationships between insureds, the aggregate effect of such change shall be revenue-neutral. The change to the new relationship shall be phased-in over a period not to exceed 3 years as approved by the department. The rate filing may also include increases based on overall experience or annual medical trend, or both, which portions shall not be phased-in over any period.

(4) In determining medical trend for application of subparagraph (1)(e)4., the department shall semiannually determine medical trend for each health care market, using reasonable actuarial techniques and standards. The trend must be adopted by the department by rule and determined as follows:

(a) Trend must be determined separately for medical expense; preferred provider organization; Medicare supplement; health maintenance organization; and other coverage for individual, small group, and large group, where applicable.

(b) The department shall survey insurers and health maintenance organizations currently issuing products and representing at least an 80-percent market share based on premiums earned in the state for the most recent calendar year for each of the categories specified in paragraph (a).

(c) Trend must be computed as the average annual medical trend approved for the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.

(d) The annual trend is the annual change in claims cost per unit of exposure. Trend includes the combined effect of medical provider price changes, changes in utilization, new medical procedures, and technology and cost shifting.

Section 3. Subsections (4) and (8) of section 627.6487, Florida Statutes, are amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(4)(a) The health insurance issuer may elect to limit the coverage offered under subsection (1) if the issuer offers at least two different policy forms of health insurance coverage, both of which:

1. Are designed for, made generally available to, actively marketed to, and enroll both eligible and other individuals by the issuer; and

2. Meet the requirement of paragraph (b).

For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms.

(b) The requirement of this subsection is met for health insurance coverage policy forms offered by an issuer in

the individual market if the issuer offers the basic and standard health benefit plans as established pursuant to s. 627.6699(12).~~policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in this state or applicable marketing or service area, as prescribed in rules adopted by the department, in the individual market in the period involved. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.~~

(8) This section does not:

(a) Restrict the issuer from applying the same nondiscriminatory underwriting and rating practices that are applied by the issuer to other individuals applying for coverage ~~amount of the premium rates that an issuer may charge an individual for individual health insurance coverage~~; or

(b) Prevent a health insurance issuer that offers individual health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 4. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) Notwithstanding any other provision of this section, any group health insurance policy or group certificate for health insurance, as described in s. 627.6561(5)(a)2., which is issued to a resident of this state and requires individual underwriting to determine coverage eligibility or premium rates to be charged shall be considered a policy issued on an individual basis and is subject to and

must comply with the Florida Insurance Code in the same manner as individual insurance policies issued in this state.

Section 5. Paragraphs (i) and (n) of subsection (3) and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(i) "Established geographic area" means the county or counties~~, or any portion of a county or counties,~~within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for: claims experience, health status, or credits based on the duration that the ~~of~~ coverage has been in force as permitted under subparagraph (6)(b)6.~~subparagraph (6)(b)5.~~; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5. A carrier may separate the experience of small employer groups with less than two eligible employees from the experience of small employer groups with two through 50 eligible employees.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by subparagraphs 5., ~~and~~ 6., and 7.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. If the modified community rate is determined from two experience pools as authorized by paragraph (5)(n), the rate to be charged to small employer groups of less than two eligible employees may not exceed 150 percent of the rate determined for groups of two through 50 eligible employees; however, the carrier may charge excess losses of the less-than-two-eligible-employee experience pool to the experience pool of the two through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less-than-two-eligible-employee experience pool is maintained. Notwithstanding the provisions of s. 627.411(1)(e)4. and (3), the rate to be charged to a small employer group of fewer than 2 eligible employees insured as of July 1, 2001, may be up to 125 percent of the rate determined for groups of 2 through 50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

4.~~3.~~ Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date

or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

5.~~4.~~ A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

6.~~5.~~ Any adjustments in rates for claims experience, health status, or credits based on the duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or credits based on the duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and

acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

7.~~6.~~ A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

8.~~7.~~ Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

Section 6. Subsection (1) of section 627.6741, Florida Statutes, is amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.--

(1) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual:

(a) To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason

of disability, and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare part B, or during the 6-month period beginning with the first month in which the individual is eligible for Medicare by reason of disability and is enrolled in Medicare part B; or

(b) To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of disability, and is enrolled in Medicare part B, who resides in this state, upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.

A Medicare supplement policy issued to an individual under paragraph (a) or paragraph (b) may not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6561(5), of at least 6 months as of the date of application for coverage. Paragraphs (a) and (b) do not apply to end-stage renal disease beneficiaries before they attain 65 years of age. For those individuals otherwise eligible under paragraph (a) or paragraph (b) who first enrolled in Medicare part B before July 1, 2001, the 6-month period shall begin on July 1, 2001. A Medicare supplemental policy issued to an individual under paragraph (a) or paragraph (b) who is less than 65 years of age and who is eligible for Medicare by reason of disability shall be issued at the premium rate for persons 65 years of age.

Section 7. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.--

(1) The department may ~~has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to administer ~~implement the provisions of~~ this part.

(2) The department may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

Section 8. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and paragraph (f) is added to that subsection, to read:

641.31 Health maintenance contracts.--

(3)

(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. This paragraph does not apply to a group contract covering 51 or more persons unless the rate is for any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(d) 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 pursuant to s. 627.411. 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.

(f) A health maintenance organization with fewer than 1,000 covered subscribers under all individual or group contracts, at the time of a rate filing, may file for an annual rate increase limited to annual medical trend, as adopted by the department. The filing is in lieu of the actuarial memorandum otherwise required for the rate filing. The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 9. This act shall take effect July 1, 2001.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR SB 1210

Deletes the provisions of the bill that would have prohibited small group carriers from considering health status or claims experience in establishing premiums.

Provides that for small employers with fewer than two employees insured on July 1, 2001, the rate may be up to 125 percent of the rate for small employers with two through fifty employees for the first annual renewal and 150 percent for subsequent annual renewals. This provision would control over any lower limit that would be imposed under s. 627.411, F.S., as amended.

Provides that small group carriers may only provide credits (not surcharges) due to duration of coverage (the time period that a small employer has been insured with the carrier).

Provides that the time period for Medicare supplement policies to be offered on a guarantee-issue basis to individuals who are eligible for Medicare by reason of disability is the six-month period after the first month in which the person is eligible for Medicare and enrolled in Medicare Part B.

Clarifies the criteria under which the Department of Insurance my disapprove health insurance rates.