HOUSE AMENDMENT

Bill No. HB 1439

Amendment No. 01 (for drafter's use only)

CHAMBER ACTION

Senate | House

ORIGINAL STAMP BELOW

The Committee on Fiscal Policy & Resources offered the following:

Amendment (with title amendment)

On page 2, line 1,

remove from the bill: everything after the enacting clause,

and insert in lieu thereof:

Section 1. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is amended, and paragraph (f) is added to subsection (7) of said section, 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. 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 claims 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(5). 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 an actuarially justified rate increase that includes 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, which rate increase is in excess of the actuarially justified rate increase without such loss-ratio change, by an amount exceeding the greater of 50 percent of annual medical trend or 5 percent;

5. Results in an actuarially justified rate increase that includes the insurer changing established rate relationships between insureds or types of coverage, which rate increase is in excess of the actuarially justified rate increase without such relationship change, to any insured by an amount exceeding the greater of 50 percent of annual medical trend or 5 percent;

6. Results in an actuarially justified rate increase that is in excess of the greater of 150 percent of annual medical trend or 10 percent attributed to the insurer not complying with the annual filing requirements of s. 627.410(7) or department rule adopted under s. 641.31; or

7. Results in an actuarially justified rate increase that is 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. This provision does not apply to prestandardized Medicare supplement forms.

(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 the renewal rate increase to existing insureds at the time of the rate filing would exceed the indicated levels based on the conditions in subparagraph (1)(e)4.,

subparagraph (1)(e)5., or subparagraph (1)(e)6., the insurer may file for approval of a higher new business rate schedule for new insureds and a rate increase of the amount that is actuarially justified by the aggregate data without such condition, plus the greater of 50 percent of annual medical trend or 5 percent for existing insureds. Future annual rate increases for the existing insureds at the time of the exercise of this provision is limited to the greater of 150 percent of the rate increase approved for new insureds, the greater of 150 percent of medical trend, or 10 percent, until the rate schedules converge. The application of this subsection is not a violation of s. 627.410(6)(d).

(4) If a rate filing changes the established rate relationship between insureds, the aggregate effect of such change shall be revenue neutral. The change to the new relationship shall be phased in under this subsection over a period not to exceed 3 years, as approved by the department.

(5) In determining medical trend for application of subparagraphs (1)(e)4., 5., 6., and 7., 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, new medical procedures, and technology and cost shifting.

Section 3. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) For purposes of this section, any insurer that issues any group health insurance policy or group certificate for health insurance to a resident of this state and requires individual underwriting to determine coverage eligibility or premium rates to be charged shall combine the experience of all association-based group policies or association-based group certificates which are substantially similar with respect to type and level of benefits and marketing method issued in this state after the policy form has been in force for a period of 5 years to calculate uniform percentage rate increases. For purposes of this section, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms. Nothing in this subsection shall be construed to require uniform rates for policies or certificates after their fifth duration, it being the intent and purpose of this law to require uniform percentage rate increases for such policies or certificates. Furthermore, nothing in this subsection shall be construed to eliminate changes in rates by age for attained age policies or

certificates. The provisions of this subsection shall apply to policies or certificates issued after July 1, 2001. For purposes of this subsection, a group health policy or group certificate for health insurance means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

Section 4. Paragraph (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:

(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 duration of coverage as permitted under 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 2 eligible employees from the experience of small employer groups with 2 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 6.~~5.~~and 7.~~6.~~

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 (3)(n), the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for groups of 2 through 50 eligible employees; however, the carrier may charge excess losses of the less than 2 eligible employee experience pool to the experience pool of the 2 through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less than 2 eligible employee experience pool is maintained.

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 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 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 5. 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 6. Paragraph (b) of subsection (3) of section 641.31, Florida Statutes, is amended, and paragraph (f) is added to said 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.

(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 7. Paragraphs (a) and (b) of subsection (1) of section 641.3155, Florida Statutes, are amended to read:

641.3155 Payment of claims.--

(1)(a) As used in this section, the term "clean claim" for a noninstitutional provider means a claim submitted on a HCFA 1500 form which has no defect or impropriety, including lack of required substantiating documentation for

noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because a health maintenance organization refers the claim to a medical specialist within the health maintenance organization for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from a source outside the health maintenance organization, the claim is considered not clean. This paragraph does not apply to claims which include potential coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.This definition of "clean claim" is repealed on the effective date of rules adopted by the department which define the term "clean claim."

(b) Absent a written definition that is agreed upon through contract, the term "clean claim" for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee. This paragraph does not apply to claims which include potential coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.

Section 8. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant portion of the residents of this state are not able to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health

care options for lower income uninsured state residents by encouraging health insurers, health maintenance organizations, health care provider sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, such options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

(2) DEFINITIONS.--As used in this section:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Approved plan" means a health flex plan approved under subsection (3) which guarantees payment by the health plan entity for specified health care services provided to the enrollee.

(c) "Enrollee" means an individual who has been determined eligible for and is receiving health benefits under a health flex plan approved under this section.

(d) "Health care coverage" means payment for health care services covered as benefits under an approved plan or that otherwise provides, either directly or through arrangements with other persons, covered health care services on a prepaid per-capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health plan entity" means a health insurer, health maintenance organization, health care provider sponsored organization, local government, health care districts, or other public or private community-based

organization that develops and implements an approved plan and is responsible for financing and paying all claims by enrollees of the plan.

(3) PILOT PROGRAM.--The agency and the Department of Insurance shall jointly approve or disapprove health flex plans which provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents as determined by the agency. A plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, cap the total amount of claims paid in 1 year per enrollee, or limit the number of enrollees covered. The agency and the Department of Insurance shall not approve or shall withdraw approval of a plan which:

(a) Contains any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

(b) Provides benefits that are unreasonable in relation to the premium charged, contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or

(c) Cannot demonstrate that the plan is financially sound and the applicant has the ability to underwrite or finance the benefits provided.

(4) LICENSE NOT REQUIRED.--A health flex plan approved under this section shall not be subject to the licensing requirements of the Florida Insurance Code or chapter 641, Florida Statutes, relating to health maintenance organizations, unless expressly made applicable. However, for

the purposes of prohibiting unfair trade practices, health flex plans shall be considered insurance subject to the applicable provisions of part IX of chapter 626, Florida Statutes, except as otherwise provided in this section.

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a) Are 64 years of age or younger;

(b) Have a family income equal to or less than 200 percent of the federal poverty level;

(c) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid, or other public health care program, including, but not limited to, Kidcare, and have not been covered at any time during the past 6 months; and

(d) Have applied for health care benefits through an approved health flex plan and agree to make any payments required for participation, including, but not limited to, periodic payments and payments due at the time health care services are provided.

(6) RECORDS.--Every health flex plan provider shall maintain reasonable records of its loss, expense, and claims experience and shall make such records reasonably available to enable the agency and the Department of Insurance to monitor and determine the financial viability of the plan, as necessary.

(7) NOTICE.--The denial of coverage by the health plan entity shall be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation shall be provided at least 45 days in advance of such nonrenewal or cancellation except that 10 days' written

notice shall be given for cancellation due to nonpayment of premiums. If the health plan entity fails to give the required notice, the plan shall remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.--Coverage under an approved health flex plan is not an entitlement and no cause of action shall arise against the state, local governmental entity, or other political subdivision of this state or the agency for failure to make coverage available to eligible persons under this section.

(9) CIVIL ACTIONS.--In addition to an administrative action initiated under subsection (4), the agency may seek any remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, Florida Statutes, if the agency finds that a health plan entity has engaged in any act resulting in injury to an enrollee covered by a plan approved under this section.

Section 9. The Legislature finds that the affordability and availability of health insurance is one of the most important and complex issues in this state and that coverage issued to a state resident under group health insurance policies issued outside the state is an important factor in meeting the needs of the citizens of this state. The Legislature also finds that it is important to ensure that those policies are adequately regulated in order to maintain the quality of the coverage offered to citizens of this state. Therefore, the Workgroup on Out of State Group Policies is hereby created to study the regulatory environment in which these policies are now offered and recommend any statutory changes that may be necessary to maintain the quality of the insurance offered in this state. There shall be four members

from the House of Representatives appointed by the Speaker of the House of Representatives and four members from the Senate appointed by the President of the Senate. The group shall begin its meetings by July 1, 2001, and complete its meetings by November 15, 2001. Recommendations for suggested legislation shall be delivered to the Speaker of the House of Representatives and the President of the Senate by December 15, 2001. At its first meeting, the group shall elect a chair from among its members.

Section 10. This act shall take effect July 1, 2001.

========== 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, through page 2, line 25, remove from the title of the bill: all of said lines,

and insert in lieu thereof:

An act relating to health insurance; amending s. 627.410, F.S.; 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. 627.6515, F.S.; providing additional experience requirements and limitations for out-of-state groups; providing construction; amending s. 627.6699, F.S.; revising a definition; 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. 627.9408, 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; providing alternative rate filing requirements for organizations with less than a specified number of subscribers; amending s. 641.3155, F.S.; specifying nonapplication of certain provisions to certain claims; providing for certain health flex plans; providing legislative intent; providing definitions; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria; exempting approved health flex plans from certain licensing

requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan providers to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying that coverage under an approved health flex plan is not an entitlement; providing for civil actions against health plan entities by the Agency for Health Care Administration under certain circumstances; providing legislative findings; creating the Workgroup on Out of State Group Policies; providing for membership; providing purposes; requiring recommendations for proposed legislation; providing an effective date.