Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate		House
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Representative Stargel offered the following:

Amendment to Amendment (209863) (with directory and title amendments)

Between lines 618-619, insert:

Section 25. Subsection (2) of section 627.6515, Florida Statutes, is amended, and subsections (9), (10), and (11) are added to said section, to read:

627.6515 Out-of-state groups.--

(2) This part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if the master policy met the filing requirements of the state of policy situs and was available for sale in the state of policy situs and:

(a) The policy is issued to an employee group the composition of which is substantially as described in s. 627.653; a labor union group or association group the

28 composition of which is substantially as described in s.
29 627.654; an additional group the composition of which is
30 substantially as described in s. 627.656; a group insured under
31 a blanket health policy when the composition of the group is
32 substantially in compliance with s. 627.659; a group insured
33 under a franchise health policy when the composition of the
34 group is substantially in compliance with s. 627.663; an
35 association group to cover persons associated in any other
36 common group, which common group is formed primarily for
37 purposes other than providing insurance; a group that is
38 established primarily for the purpose of providing group
39 insurance, provided the benefits are reasonable in relation to
40 the premiums charged thereunder and the issuance of the group
41 policy has resulted, or will result, in economies of
42 administration; or a group of insurance agents of an insurer,
43 which insurer is the policyholder;

44 (b) Certificates evidencing coverage under the policy are
45 issued to residents of this state and contain in contrasting
46 color and not less than 10-point type the following statement:
47 "The benefits of the policy providing your coverage are governed
48 primarily by the law of a state other than Florida"; ~~and~~

49 (c) The policy provides the benefits specified in ss.
50 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121,
51 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911

52 (d) Applications for certificates of coverage offered to
53 residents of this state contain in contrasting color and not
54 less than 12-point type the following statement on the same page
55 as the applicant signature: "This policy is primarily governed
56 by the laws of {insert state where the master policy is filed}.

57 As a result, all of the rating laws applicable to policies filed
58 in Florida do not apply to this coverage, which may result in
59 increases in your premium at renewal that would not be
60 permissible under a Florida-approved policy. Any purchase of
61 individual health insurance should be considered carefully, as
62 future medical conditions may make it impossible to qualify for
63 another individual health policy. For information concerning
64 individual health coverage under a Florida-approved policy,
65 consult your agent or the Florida Department of Financial
66 Services." The provisions of this paragraph only apply to group
67 certificates for health insurance coverage, as described in s.
68 627.6561(5) (a) 2., which require individual underwriting to
69 determine coverage eligibility for an individual or premium
70 rates to be charged to an individual.
71 (9)(a) For purposes of this section, any insurer that
72 issues any group health benefit plan, as defined in s. 627.6699
73 (3)(k), except for policies issued to provide coverage to groups
74 of persons all of whom are in the same or functionally related
75 licensed professions, and providing coverage only to such
76 licensed professionals, their employees or their dependents, to
77 a resident of this state requiring individual underwriting to
78 determine eligibility for coverage or initial premiums rates to
79 be charged, shall not take into account the individual claims
80 experience or any change in the personal health status of a
81 covered person that occurs after the initial issuance of the
82 health benefit plan to determine his or her renewal premium
83 rates. No premium increase, including a reduced premium
84 increasing the form of a discount, may be implemented for an
85 insured individual under existing group health plan coverage

86 subsequent to the initial effective date of coverage under such
87 policy or certificate to the extent that such reduction in
88 benefits is determined based upon a change in a health-status
89 related factor of the individual insured or the past or
90 prospective claim experience of the individual insured. No
91 modifications to contractual terms and conditions may be
92 implemented for an insured individual under existing group
93 health coverage subsequent to the initial effective date of
94 coverage under such policy or certificate to the extent that
95 such modifications to contractual terms and conditions are
96 determined based upon a change in a health-status related factor
97 of the individual insured or the past or prospective claim
98 experience of the individual insured. Nothing in this section
99 shall be construed to require uniform premium rates, to restrict
100 the use of any rating factors, or to restrict experience-based
101 renewal premium rating practices that are applied to all
102 individual insureds by a particular health benefit plan or group
103 of health benefit plans The stated intent and purpose of this
104 subsection is to prohibit renewal premium practices that are
105 based exclusively upon a covered person's individual claim
106 experience or a change in a covered person's personal health
107 status. A certification shall be made by a qualified actuary
108 who is a member of the Society of Actuaries or the American
109 Academy of Actuaries and who is qualified in the area of health
110 insurance that the insurer's premium structure complies with
111 this subsection.
112 (b) If an insurer has ever utilized the renewal premium
113 adjustments prohibited above, the insurer must file new renewal
114 premium rates with the department for informational purposes

115 only. The new rates must eliminate the effects of the prohibited
116 renewal premium adjustments on a revenue neutral basis. This new
117 renewal premium rate filing must be accompanied by a
118 certification by a qualified actuary who is a member of the
119 Society of Actuaries or the American Academy of Actuaries that
120 the filing complies with the requirements of this act. The
121 filing must be made within 90 days after the effective day of
122 this act. The new renewal premium rates must be implemented
123 within 90 days after the filing. This provision shall not
124 prohibit adjustments in an individual's premiums in lieu of a
125 rescission that would be allowed under applicable law due to a
126 fraudulent or material misstatement in an application or based
127 upon changes required by law, benefit changes requested by the
128 insured, or a requested reinstatement of lapsed coverage.
129 (c) For purposes of this subsection, group health benefit
130 plan means any hospital or medical policy, hospital or medical
131 service plan contract, or health maintenance organization
132 subscriber contract. The term does not include accidental death,
133 accidental death and dismemberment, accident-only, vision-only,
134 dental-only, hospital indemnity, hospital accident, cancer,
135 specified disease, Medicare supplement, products that supplement
136 Medicare, long-term care, or disability income insurance,
137 similar supplemental plans provided under a separate policy,
138 certificate, or contract of insurance, which can not duplicate
139 coverage under an underlying health plan and are specifically
140 designed to fill gaps in the underlying health plan,
141 coinsurance, or deductibles; coverage issued as a supplement to
142 liability insurance, worker's compensation or similar insurance,
143 or automobile medical-payment insurance.

144 (d) For purposes of this subsection, any insurer that
145 issues any group health benefit plan as defined in s.
146 627.6699(3)(k), except for policies issued to provide coverage
147 to groups of persons of whom are in the same or functionally
148 related licensed professions, and providing coverage only to
149 such licensed professionals, their employees or their
150 dependents, under which a resident of this state is provided
151 coverage which has been in force for a period of three years,
152 and which applies individual underwriting to determine
153 eligibility or premium rates charged, shall not increase premium
154 rate tables charged to a resident of this state by a percentage
155 greater than the percentage increases applied to premium rate
156 tables charged to a resident of this state for coverage which
157 has been in force for a period of three years under any
158 substantially similar group health benefit plan. The commission
159 may adopt rules to establish the meaning of "substantially
160 similar benefits." During the first 3 years of coverage, the
161 percentage increase in the premium rate charged to an individual
162 member of an association group for a new rating period may not
163 exceed the sum of the following:
164 1. The percentage change in the new business premium rate
165 measured from the first day of the prior rating period to the
166 first day of the new rating period. In the case of a carrier
167 which is not issuing new health benefit plans covering members
168 of an association group, the carrier shall use the percentage
169 change in the base premium rate.
170 2. An adjustment, not to exceed 20 percent annually and
171 adjusted pro-rata for rating period of less than one year, due
172 to the claim experience, health status or duration of coverage

173 of all individuals with coverage under health benefit plans with
174 the same or similar benefits.
175 3. Any adjustment due to change in coverage or change in
176 the case characteristic of the insured individuals. "Case
177 characteristics" mean demographic or other relevant
178 characteristics of individuals which are considered by the
179 carrier in the determination of premium rates, which may
180 include, but are not limited to, age, gender, geography, family
181 composition, occupation, tobacco-usage, and healthy lifestyle
182 discounts. Case characteristics shall not include claim
183 experience, health status and duration of coverage since issue.
184
185 Nothing herein shall be construed to require uniform rates for
186 substantially similar policies or certificates after their third
187 year of duration, it being the intent and purpose of this law to
188 require uniform maximum percentage rate increases for such
189 policies or certificates issued after the effective date of this
190 subsection. This subsection shall apply to all policies issued
191 or renewed after the effective date of this act. A certification
192 shall be made by a qualified actuary who is a member of the
193 Society of Actuaries or the American Academy of Actuaries and
194 who is qualified in the area of health insurance that the
195 insurer's premium structure complies with this subsection.
196 (e) For purposes of this subsection, group health benefit
197 plan means any hospital or medical policy, hospital or medical
198 service plan contract, or health maintenance organization
199 subscriber contract. The term does not include accidental
200 death, accidental death and dismemberment, accident-only,
201 vision-only, dental only, hospital indemnity, hospital accident,

202 cancer, specified disease, Medicare supplement, products that
203 supplement Medicare, long-term care, or disability income
204 insurance, similar supplemental plans provided under a separate
205 policy, certificate, or contract of insurance, which can not
206 duplicate coverage under an underlying health plan and are
207 specifically designed to fill gaps in the underlying health
208 plan, coinsurance, or deductibles; coverage issued as a
209 supplement to liability insurance; worker's compensation, or
210 similar insurance; or automobile medical payment insurance.

211 (11) Any person insured under a certificate issued through
212 a group health benefit plan who voluntarily terminates such
213 certificate shall not be eligible for coverage under any other
214 group health insurance policy issued by the same insurer to that
215 same association for a period of six months from the date such
216 certificate was terminated, unless such new policy is available
217 to all other insureds under the existing policy without regard
218 to health status and at the same rate for all similarly situated
219 individuals. This subsection shall not apply to short-term
220 limited duration health insurance or to new coverage options
221 made available as a result of a change in law subsequent to the
222 initial issuance of a certificate.

223 Section 26. Paragraph (a) of subsection (6) of section
224 627.410, Florida Statutes, is amended to read:

225 627.410 Filing, approval of forms.--

226 (6)(a) An insurer shall not deliver or issue for delivery
227 or renew in this state any health insurance policy form until it
228 has filed with the department a copy of every applicable rating
229 manual, rating schedule, change in rating manual, and change in
230 rating schedule; if rating manuals and rating schedules are not

231 applicable, the insurer must file with the department applicable
232 premium rates and any change in applicable premium rates.
233 (b) This subsection ~~paragraph~~ does not apply to group
234 health insurance policies:~~,~~
235 1. Effectuated and delivered in this state, insuring
236 groups of 51 or more persons, except for Medicare supplement
237 insurance, long-term care insurance, and any coverage under
238 which the increase in claim costs over the lifetime of the
239 contract due to advancing age or duration is prefunded in the
240 premium.
241 2.a. Effectuated and delivered outside this state, but
242 covering residents of this state, except for policies issued to
243 provide coverage to groups of persons all of whom are in the
244 same or functionally related licensed professions, and providing
245 coverage only to such licensed professionals, their employees or
246 their dependents, if the insurer meet the requirements of s.
247 627.6515, files its rates with the Office of Insurance
248 Regulation for information purposes only, and the filing of
249 rates is accompanied by an actuarial certification that the loss
250 ratios for the certificates delivered or issue for delivery in
251 this state meet or exceed a loss ratio in each year following
252 the third year of duration for incurred claims to earned premium
253 of 65 percent for group policies, and certificates reflecting
254 coverage thereunder, issued on or after the effective date of
255 this Act. The 65 percent loss ratio does not apply to accidental
256 death, accidental death and dismemberment, accident-only,
257 vision-only, dental only, hospital indemnity, hospital accident,
258 cancer, specified disease, or disability income insurance,
259 similar supplemental plans provided under a separate policy,

260 certificate, or contract of insurance, which can not duplicate
261 coverage under an underlying health plan and are specifically
262 designed to fill gaps in the underlying health plan,
263 coinsurance, or deductibles; coverage issued as a supplement to
264 liability insurance; worker’s compensation, or similar
265 insurance; or automobile medical payment insurance.
266 b. As used in this subsection, the actuarial certification
267 shall be made by a qualified actuary who is a member of the
268 Society of Actuaries or the American Academy of Actuaries and
269 who is qualified in the area of health insurance.
270 b. For purposes of this subsection, group health insurance
271 policy means any hospital or medical policy, hospital or medical
272 service plan contract, or health maintenance organization
273 subscriber contract. The term does not include accidental
274 death, accidental death and dismemberment, accident-only,
275 vision-only, dental-only, hospital indemnity, hospital accident,
276 cancer, specified disease, limited-benefit, disability income
277 insurance, or similar supplemental plans provided under a
278 separate policy, certificate, or contract of insurance, which
279 can not duplicate coverage under an underlying health plan and
280 are specifically designed to fill gaps in the underlying health
281 plan, coinsurance, or deductibles; coverage issued as a
282 supplement to liability insurance; worker's compensation, or
283 similar insurance; or automobile medical-payment insurance."
284 3. Effectuated and delivered to a bona fide association
285 which means, with respect to health insurance coverage offered
286 in a State, an association which:
287 a. Has been actively in existence for at least 5 years.

288 b. Has been formed and maintained in good faith for
289 purposes other than obtaining insurance.
290 c. Does not condition membership in the association on any
291 health status-related factor relating to an individual,
292 including an employee of an employer or a dependent of an
293 employee.
294 d. Makes health insurance coverage offered through the
295 association available to all members regardless of any health
296 status-related factor relating to such members, or individuals
297 eligible for coverage through a member.
298 e. Does not make health insurance coverage offered through
299 the association available other than in connection with a member
300 of the association.
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302
303
304 ================ T I T L E A M E N D M E N T ================
305 Remove line(s) 66, and insert:
306 to subscribers; amending s. 627.6515, F.S.; limiting application
307 of certain provisions to group health insurance policies issued
308 or delivered outside the state; providing requirements for
309 certain applications for certificates of coverage; specifying
310 requirements, criteria, and limitations on issuing group health
311 benefit plans; authorizing the commission to adopt rules;
312 providing premium rate increase limitations; providing
313 construction; providing definitions; limiting coverage
314 eligibility under certain circumstances; amending s. 627.410,
315 F.S.; providing additional limitations on applications to group

Amendment No. (for drafter’s use only)

316 health insurance policies; providing definitions; providing an
317 effective date.

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