By the Committees on Health, Aging, and Long-Term Care; Banking and Insurance; and Senator Atwater

317-2490-03

A bill to be entitled

An act relating to health insurance; amending s. 627.411, F.S.; revising grounds for disapproval of health insurance policy forms that apply certain rating practices, or that result in actuarially justified rate increases under certain circumstances; requiring health insurance policies to meet a minimum loss ratio of a specified amount; amending s. 627.6515, F.S.; amending conditions that must be met to exempt from part VII of ch. 627, F.S., a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage; providing rulemaking authority; providing an effective date.

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

Section 1. 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 commission 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. This sub-subparagraph does not apply to pre-standardized 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)(a) For health insurance coverage as described in s. 627.6561(5)(a)2., the minimum loss ratio standard of incurred claims to earned premium for the form shall be 65 percent.

(b) Incurred claims are claims occurring within a fixed period, whether or not paid during the same period, under the terms of the policy period.

1. Claims include scheduled benefit payments, or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.

2. Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services.

3. A company may at its discretion include costs that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5 percent.

4. For scheduled claim payments, such as disability income or long-term care, the incurred claims shall be the

present value of the benefit payments discounted for continuance and interest.

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

627.6515 Out-of-state groups.--

(2) Except as provided in this part, 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:

(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 composition of which is substantially as described in s. 627.654; an additional group the composition of which is substantially as described in s. 627.656; a group insured under a blanket health policy when the composition of the group is substantially in compliance with s. 627.659; a group insured under a franchise health policy when the composition of the group is substantially in compliance with s. 627.663 and the policy was issued prior to January 1, 2003; an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; a group that is established primarily for the purpose of providing group insurance, provided the benefits are reasonable in relation to the premiums charged thereunder and the issuance of the group policy has resulted, or will result, in economies of administration; or a group of insurance agents of an insurer, which insurer is the policyholder;

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

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

(d) For policies or contracts issued on or after October 1, 2003, regardless of the type of group described in this subsection to which the policy is issued, except for policies issued to provide coverage to groups of persons all of whom are in the same or functionally related licensed professions, and providing coverage only to such licensed professionals, their employees or their dependents, the policy complies with the antidiscrimination provisions set forth in s. 627.65625, regarding rating and eligibility for enrollment and for any benefit under the policy, and with s. 627.6571; and

(e) The policy is not issued to a group, other than an employer group for the benefit of its employees, that directly or indirectly uses any health status related factor, as described in s. 627.65625, in determining eligibility for initial or continued membership in the group or initial or continued eligibility of any group member to participate in any aspect of the group insurance program.

For purposes of paragraphs (d) and (e), group health insurance policy means any hospital or medical policy, hospital or

medical service plan contract, or health maintenance organization subscriber contract. The term does not include accidental death, accidental death and dismemberment, accident-only, vision-only, dental-only, hospital indemnity, hospital accident, cancer, specified disease, Medicare Supplement, products that supplement Medicare, 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. The provisions of paragraphs (d) and (e) shall not apply to policies providing coverage to small employers as defined by s. 627.6699. Such policies shall be subject to, and governed by, the provisions of s. 627.6699. The provisions of paragraphs (d) and (e) shall not apply to a policy issued to a bona fide association, as defined by s. 627.6571(5), provided that there is a person or board acting as a fiduciary for the benefit of the members; such association is not owned, controlled by, or otherwise associated with the insurance company; and the renewal rate changes are the same uniform percentage adjustment for all covered members.

(9) The Financial Services Commission shall adopt rules necessary to administer this section.

(10) The Financial Services Commission may adopt rules to establish standards for exempting certain groups from the provisions of paragraphs (2)(d) and (e). Such rules shall establish standards for determining that the members of the

group policy are provided protection from rate escalations from the segregation of risks and that members are provided protection by an individual or board that is not owned or controlled by the carrier or affiliate of the carrier and acts in a fiduciary capacity for the protection of its members. The office must provide, upon request of an insurer, a 90-day exemption from the October 1, 2003, effective date of paragraphs (2)(d) and (e) to any insurer:

(a) Having an approved filing for individual business by October 1, 2003; and

(b) Certifying that each individual issued a policy or certificate after October 1, 2003, will be offered the opportunity to switch his or her policy to the new form at the end of the exemption period.

The provisions of paragraphs (2)(d) and (e) do not apply to policies or certificates issued prior to October 1, 2003.

Section 3. This act shall take effect July 1, 2003.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS/SB 2264

The Committee Substitute clarifies that policies providing coverage to small employers which are governed under s. 627.6699, F.S., and a policy issued by a bona fide association as defined by s. 627.6571(5), F.S., provided it meets requirements specified in the bill, are exempt from the provisions of Part VII of ch. 627, F.S.