Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Stargel offered the following:

Substitute Amendment for Amendment (284651) (with directory and title amendments)

Between lines 1320 and 1321, 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

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

As a result, all of the rating laws applicable to policies filed in Florida do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services." The provisions of this paragraph only apply to group certificates for health insurance coverage, as described in s. 627.6561(5) (a) 2., which require individual underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual.

(9)(a) For purposes of this section, any insurer that issues any group health benefit plan, as defined in s. 627.6699 (3)(k), 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, to a resident of this state requiring individual underwriting to determine eligibility for coverage or initial premiums rates to be charged, shall not take into account the individual claims experience or any change in the personal health status of a covered person that occurs after the initial issuance of the health benefit plan to determine his or her renewal premium rates. No premium increase, including a reduced premium increasing the form of a discount, may be implemented for an insured individual under existing group health plan coverage

subsequent to the initial effective date of coverage under such policy or certificate to the extent that such reduction in benefits is determined based upon a change in a health-status related factor of the individual insured or the past or prospective claim experience of the individual insured. No modifications to contractual terms and conditions may be implemented for an insured individual under existing group health coverage subsequent to the initial effective date of coverage under such policy or certificate to the extent that such modifications to contractual terms and conditions are determined based upon a change in a health-status related factor of the individual insured or the past or prospective claim experience of the individual insured. Nothing in this section shall be construed to require uniform premium rates, to restrict the use of any rating factors, or to restrict experience-based renewal premium rating practices that are applied to all individual insureds by a particular health benefit plan or group of health benefit plans The stated intent and purpose of this subsection is to prohibit renewal premium practices that are based exclusively upon a covered person's individual claim experience or a change in a covered person's personal health status. A certification shall be made by a qualified actuary who is a member of the Society of Actuaries or the American Academy of Actuaries and who is qualified in the area of health insurance that the insurer's premium structure complies with this subsection.

(b) If an insurer has ever utilized the renewal premium adjustments prohibited above, the insurer must file new renewal premium rates with the department for informational purposes

only. The new rates must eliminate the effects of the prohibited renewal premium adjustments on a revenue neutral basis. This new renewal premium rate filing must be accompanied by a certification by a qualified actuary who is a member of the Society of Actuaries or the American Academy of Actuaries that the filing complies with the requirements of this act. The filing must be made within 90 days after the effective day of this act. The new renewal premium rates must be implemented within 90 days after the filing. This provision shall not prohibit adjustments in an individual’s premiums in lieu of a rescission that would be allowed under applicable law due to a fraudulent or material misstatement in an application or based upon changes required by law, benefit changes requested by the insured, or a requested reinstatement of lapsed coverage.

(c) For purposes of this subsection, group health benefit plan 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 can not 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, worker's compensation or similar insurance, or automobile medical-payment insurance.

(d) For purposes of this subsection, any insurer that issues any group health benefit plan as defined in s. 627.6699(3)(k), except for policies issued to provide coverage to groups of persons of whom are in the same or functionally related licensed professions, and providing coverage only to such licensed professionals, their employees or their dependents, under which a resident of this state is provided coverage which has been in force for a period of three years, and which applies individual underwriting to determine eligibility or premium rates charged, shall not increase premium rate tables charged to a resident of this state by a percentage greater than the percentage increases applied to premium rate tables charged to a resident of this state for coverage which has been in force for a period of three years under any substantially similar group health benefit plan. The commission may adopt rules to establish the meaning of "substantially similar benefits." During the first 3 years of coverage, the percentage increase in the premium rate charged to an individual member of an association group for a new rating period may not exceed the sum of the following:

1. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a carrier which is not issuing new health benefit plans covering members of an association group, the carrier shall use the percentage change in the base premium rate.

2. An adjustment, not to exceed 20 percent annually and adjusted pro-rata for rating period of less than one year, due to the claim experience, health status or duration of coverage

of all individuals with coverage under health benefit plans with the same or similar benefits.

3. Any adjustment due to change in coverage or change in the case characteristic of the insured individuals. "Case characteristics" mean demographic or other relevant characteristics of individuals which are considered by the carrier in the determination of premium rates, which may include, but are not limited to, age, gender, geography, family composition, occupation, tobacco-usage, and healthy lifestyle discounts. Case characteristics shall not include claim experience, health status and duration of coverage since issue.

Nothing herein shall be construed to require uniform rates for substantially similar policies or certificates after their third year of duration, it being the intent and purpose of this law to require uniform maximum percentage rate increases for such policies or certificates issued after the effective date of this subsection. This subsection shall apply to all policies issued or renewed after the effective date of this act. A certification shall be made by a qualified actuary who is a member of the Society of Actuaries or the American Academy of Actuaries and who is qualified in the area of health insurance that the insurer's premium structure complies with this subsection.

(e) For purposes of this subsection, group health benefit plan 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 can not 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; worker's compensation, or similar insurance; or automobile medical payment insurance.

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

Section 26. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is 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) This subsection ~~paragraph~~ does not apply to group health insurance policies:~~,~~

1. Effectuated and delivered in this state, 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.

2.a. Effectuated and delivered outside this state, but covering residents of this state, 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, if the insurer meet the requirements of s. 627.6515, files its rates with the Office of Insurance Regulation for information purposes only, and the filing of rates is accompanied by an actuarial certification that the loss ratios for the certificates delivered or issue for delivery in this state meet or exceed a loss ratio in each year following the third year of duration for incurred claims to earned premium of 65 percent for group policies, and certificates reflecting coverage thereunder, issued on or after the effective date of this Act. The 65 percent loss ratio does not apply to accidental death, accidental death and dismemberment, accident-only, vision-only, dental only, hospital indemnity, hospital accident, cancer, specified disease, or disability income insurance, similar supplemental plans provided under a separate policy,

certificate, or contract of insurance, which can not 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; worker’s compensation, or similar insurance; or automobile medical payment insurance.

b. As used in this subsection, the actuarial certification shall be made by a qualified actuary who is a member of the Society of Actuaries or the American Academy of Actuaries and who is qualified in the area of health insurance.

b. For purposes of this subsection, 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, limited-benefit, disability income insurance, or similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which can not 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; worker's compensation, or similar insurance; or automobile medical-payment insurance."

3. Effectuated and delivered to a bona fide association which means, with respect to health insurance coverage offered in a State, an association which:

a. Has been actively in existence for at least 5 years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee.

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members, or individuals eligible for coverage through a member.

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

========== T I T L E A M E N D M E N T ==========

Remove line(s) 73, and insert:
cross references; amending s. 627.6515, F.S.; limiting application of certain provisions to group health insurance policies issued or delivered outside the state; providing requirements for certain applications for certificates of coverage; specifying requirements, criteria, and limitations on issuing group health benefit plans; authorizing the commission to adopt rules; providing premium rate increase limitations; providing construction; providing definitions; limiting coverage eligibility under certain circumstances; amending s. 627.410, F.S.; providing additional limitations on applications to group

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