CHAMBER ACTION

Senate . House
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Representative Negron, Berfield, Llorente, and Farkas offered the following:

Amendment (with title amendment)

Between line(s) 1320 and 1321, insert:

Section 25. 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

27 which deceptively affect the risk purported to be assumed in the
28 general coverage of the contract.

29 (c) Has any title, heading, or other indication of its
30 provisions which is misleading.

31 (d) Is printed or otherwise reproduced in such manner as
32 to render any material provision of the form substantially
33 illegible.

34 (e) Is for health insurance~~,~~ and:

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

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

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

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

46 a. Attributed to the insurer reducing the portion of the
47 premium used to pay claims from the loss ratio standard
48 certified in the last actuarial certification filed by the
49 insurer, in excess of the greater of 50 percent of annual
50 medical trend or 5 percent. At its option, the insurer may file
51 for approval of an actuarially justified new business rate
52 schedule for new insureds and a rate increase for existing
53 insureds that is equal to the greater of 150 percent of annual
54 medical trend or 10 percent. Future annual rate increases for
55 existing insureds shall be limited to the greater of 150 percent

56 of the rate increase approved for new insureds or 10 percent
57 until the two rate schedules converge;
58 b. In excess of the greater of 150 percent of annual
59 medical trend or 10 percent and the company did not comply with
60 the annual filing requirements of s. 627.410(7) or commission
61 rule for health maintenance organizations pursuant to s. 641.31.
62 At its option, the insurer may file for approval of an
63 actuarially justified new business rate schedule for new
64 insureds and a rate increase for existing insureds that is equal
65 to the rate increase allowed by the preceding sentence. Future
66 annual rate increases for existing insureds shall be limited to
67 the greater of 150 percent of the rate increase approved for new
68 insureds or 10 percent until the two rate schedules converge; or
69 c. In excess of the greater of 150 percent of annual
70 medical trend or 10 percent on a form or block of pooled forms
71 in which no form is currently available for sale. This sub-
72 subparagraph does not apply to pre-standardized Medicare
73 supplement forms ~~in sales practices~~.
74 (f) Excludes coverage for human immunodeficiency virus
75 infection or acquired immune deficiency syndrome or contains
76 limitations in the benefits payable, or in the terms or
77 conditions of such contract, for human immunodeficiency virus
78 infection or acquired immune deficiency syndrome which are
79 different than those which apply to any other sickness or
80 medical condition.
81 (2) In determining whether the benefits are reasonable in
82 relation to the premium charged, the department, in accordance
83 with reasonable actuarial techniques, shall consider:

84 (a) Past loss experience and prospective loss experience
85 within and without this state.
86 (b) Allocation of expenses.
87 (c) Risk and contingency margins, along with justification
88 of such margins.
89 (d) Acquisition costs.
90 (3)(a) For health insurance coverage as described in s.
91 627.6561(5)(a)2., the minimum loss ratio standard of incurred
92 claims to earned premium for the form shall be 65 percent.
93 (b) Incurred claims are claims occurring within a fixed
94 period, whether or not paid during the same period, under the
95 terms of the policy period.
96 1. Claims include scheduled benefit payments, or services
97 provided by a provider or through a provider network for dental,
98 vision, disability, and similar health benefits.
99 2. Claims do not include state assessments, taxes, company
100 expenses, or any expense incurred by the company for the cost of
101 adjusting and settling a claim, including the review,
102 qualification, oversight, management, or monitoring of a claim
103 or incentives or compensation to providers for other than the
104 provisions of health care services.
105 3. A company may, at its discretion, include costs that
106 are demonstrated to reduce claims, such as fraud intervention
107 programs or case management costs, which are identified in each
108 filing, are demonstrated to reduce claims costs, and do not
109 result in increasing the experience period loss ratio by more
110 than 5 percent.
111 4. For scheduled claim payments, such as disability income
112 or long-term care, the incurred claims shall be the present

113 value of the benefit payments discounted for continuance and
114 interest.
115 Section 26. Subsection (2) of section 627.6515, Florida
116 Statutes, is amended, and subsections (9) and (10) are added to
117 said section, to read:
118 627.6515 Out-of-state groups.--
119 (2) Except as provided in this part, this part does not
120 apply to a group health insurance policy issued or delivered
121 outside this state under which a resident of this state is
122 provided coverage if:
123 (a) The policy is issued to an employee group the
124 composition of which is substantially as described in s.
125 627.653; a labor union group or association group the
126 composition of which is substantially as described in s.
127 627.654; an additional group the composition of which is
128 substantially as described in s. 627.656; a group insured under
129 a blanket health policy when the composition of the group is
130 substantially in compliance with s. 627.659; a group insured
131 under a franchise health policy when the composition of the
132 group is substantially in compliance with s. 627.663 and the
133 policy was issued prior to January 1, 2003; an association group
134 to cover persons associated in any other common group, which
135 common group is formed primarily for purposes other than
136 providing insurance; a group that is established primarily for
137 the purpose of providing group insurance, provided the benefits
138 are reasonable in relation to the premiums charged thereunder
139 and the issuance of the group policy has resulted, or will
140 result, in economies of administration; or a group of insurance
141 agents of an insurer, which insurer is the policyholder;

142 (b) Certificates evidencing coverage under the policy are
143 issued to residents of this state and contain in contrasting
144 color and not less than 10-point type the following statement:
145 "The benefits of the policy providing your coverage are governed
146 primarily by the law of a state other than Florida"; ~~and~~
147 (c) The policy provides the benefits specified in ss.
148 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121,
149 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and
150 627.66911;~~.~~
151 (d) For the policies or contracts issued on or after
152 October 1, 2003, regardless of the type of group described in
153 this subsection to which the policy is issued, except for
154 policies issued to provide coverage to groups of persons all of
155 whom are in the same or functionally related licensed
156 professions, and providing coverage only to such licensed
157 professionals, their employees or their dependents, or to a bona
158 fide association as defined in s. 627.6571(5), the policy
159 complies with the antidiscrimination provisions set forth in s.
160 627.65625, regarding rating and eligibility for enrollment and
161 for any benefit under the policy, and with s. 627.6571;
162 (e) For the policies or contracts issued on or after
163 October 1, 2003, the policy is not issued to a group, other than
164 an employer group for the benefit of its employees, that
165 directly or indirectly uses any health-status-related factor, as
166 described in s. 627.65625, in determining eligibility for
167 initial or continued membership in the group or initial or
168 continued eligibility of any group member to participate in any
169 aspect of the group insurance program; and

170 (f) For the purposes of paragraphs (d) and (e), "group
171 health insurance policy" means any hospital or medical policy,
172 hospital or medical service plan contract, or health maintenance
173 organization subscriber contract. The term does not include
174 accidental death, accidental death and dismemberment, accident-
175 only, vision-only, dental-only, hospital indemnity, hospital
176 accident, cancer, specified disease, Medicare supplement,
177 products that supplement Medicare, long-term care, or disability
178 income insurance, similar supplemental plans provided under a
179 separate policy, certificate, or contract of insurance, which
180 cannot duplicate coverage under an underlying health plan and
181 are specifically designed to fill gaps in the underlying health
182 plan, coinsurance, or deductibles; coverage issued as a
183 supplement to liability insurance; workers' compensation or
184 similar insurance; or automobile medical payment insurance.
185 (9) The Financial Services Commission shall adopt rules
186 necessary to administer this section.
187 (10) The Financial Services Commission may adopt rules to
188 establish standards for exempting certain groups from the
189 provisions of paragraphs (2)(d) and (e). Such rules shall
190 establish standards for determining that the members of the
191 group policy are provided protection from rate escalations from
192 the segregation of risks and that members are provided
193 protection by an individual or board that is not owned or
194 controlled by the carrier or affiliate of the carrier and acts
195 in a fiduciary capacity for the protection of its members. The
196 office must provide, upon request of an insurer, a 90-day
197 exemption from the October 1, 2003, effect date of paragraphs
198 (2)(d) and (e) to any insurer:

199 (a) Having an approved filing for individual business by
200 October 1, 2003; and
201 (b) Certifying that each individual issued a policy or
202 certificate after October 1, 2003, will be offered the
203 opportunity to switch his or her policy to the new form at the
204 end of the exemption period.
205
206 The provisions of paragraphs (2)(d) and (e) do not apply to
207 policies or certificates issued prior to October 1, 2003.
208
209 ================= T I T L E A M E N D M E N T =================
210 Remove line(s) 73, and insert:
211 cross references; amending s. 627.411, F.S.; revising grounds
212 for disapproval of health insurance policy forms that apply
213 certain rating practices or that result in actuarially justified
214 rate increases under certain circumstances; requiring health
215 insurance policies to meet a minimum loss ratio of a specified
216 amount; amending s. 627.6515, F.S.; amending conditions that
217 must be met to exempt from part VII of ch. 627, F.S., a group
218 health insurance policy issued or delivered outside this state
219 under which a resident of this state is provided coverage;
220 providing rulemaking authority; providing an effective date.