Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate . House
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Representative Negron offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause, and insert:

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.

28 (c) Has any title, heading, or other indication of its
29 provisions which is misleading.
30 (d) Is printed or otherwise reproduced in such manner as
31 to render any material provision of the form substantially
32 illegible.
33 (e) Is for health insurance~~,~~ and:
34 1. Provides benefits that ~~which~~ are unreasonable in
35 relation to the premium charged;~~,~~
36 2. Contains provisions that ~~which~~ are unfair or
37 inequitable or contrary to the public policy of this state or
38 that ~~which~~ encourage misrepresentation;~~, or~~
39 3. Contains provisions that ~~which~~ apply rating practices
40 that ~~which result in premium escalations that are not viable for~~
41 ~~the policyholder market or~~ result in unfair discrimination
42 pursuant to s. 626.9541(1)(g)2.; or
43 4. Results in actuarially justified rate increases on an
44 annual basis:
45 a. Attributed to the insurer reducing the portion of the
46 premium used to pay claims from the loss ratio standard
47 certified in the last actuarial certification filed by the
48 insurer, in excess of the greater of 50 percent of annual
49 medical trend or 5 percent. At its option, the insurer may file
50 for approval of an actuarially justified new business rate
51 schedule for new insureds and a rate increase for existing
52 insureds that is equal to the greater of 150 percent of annual
53 medical trend or 10 percent. Future annual rate increases for
54 existing insureds shall be limited to the greater of 150 percent
55 of the rate increase approved for new insureds or 10 percent
56 until the two rate schedules converge;

57 b. In excess of the greater of 150 percent of annual
58 medical trend or 10 percent and the company did not comply with
59 the annual filing requirements of s. 627.410(7) or commission
60 rule for health maintenance organizations pursuant to s. 641.31.
61 At its option, the insurer may file for approval of an
62 actuarially justified new business rate schedule for new
63 insureds and a rate increase for existing insureds that is equal
64 to the rate increase allowed by the preceding sentence. Future
65 annual rate increases for existing insureds shall be limited to
66 the greater of 150 percent of the rate increase approved for new
67 insureds or 10 percent until the two rate schedules converge; or
68 c. In excess of the greater of 150 percent of annual
69 medical trend or 10 percent on a form or block of pooled forms
70 in which no form is currently available for sale. This sub-
71 subparagraph does not apply to pre-standardized Medicare
72 supplement forms ~~in sales practices~~.
73 (f) Excludes coverage for human immunodeficiency virus
74 infection or acquired immune deficiency syndrome or contains
75 limitations in the benefits payable, or in the terms or
76 conditions of such contract, for human immunodeficiency virus
77 infection or acquired immune deficiency syndrome which are
78 different than those which apply to any other sickness or
79 medical condition.
80 (2) In determining whether the benefits are reasonable in
81 relation to the premium charged, the department, in accordance
82 with reasonable actuarial techniques, shall consider:
83 (a) Past loss experience and prospective loss experience
84 within and without this state.
85 (b) Allocation of expenses.

86 (c) Risk and contingency margins, along with justification
87 of such margins.
88 (d) Acquisition costs.
89 (3)(a) For health insurance coverage as described in s.
90 627.6561(5)(a)2., the minimum loss ratio standard of incurred
91 claims to earned premium for the form shall be 65 percent.
92 (b) Incurred claims are claims occurring within a fixed
93 period, whether or not paid during the same period, under the
94 terms of the policy period.
95 1. Claims include scheduled benefit payments, or services
96 provided by a provider or through a provider network for dental,
97 vision, disability, and similar health benefits.
98 2. Claims do not include state assessments, taxes, company
99 expenses, or any expense incurred by the company for the cost of
100 adjusting and settling a claim, including the review,
101 qualification, oversight, management, or monitoring of a claim
102 or incentives or compensation to providers for other than the
103 provisions of health care services.
104 3. A company may, at its discretion, include costs that
105 are demonstrated to reduce claims, such as fraud intervention
106 programs or case management costs, which are identified in each
107 filing, are demonstrated to reduce claims costs, and do not
108 result in increasing the experience period loss ratio by more
109 than 5 percent.
110 4. For scheduled claim payments, such as disability income
111 or long-term care, the incurred claims shall be the present
112 value of the benefit payments discounted for continuance and
113 interest.

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

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

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

200 (b) Certifying that each individual issued a policy or
201 certificate after October 1, 2003, will be offered the
202 opportunity to switch his or her policy to the new form at the
203 end of the exemption period.
204
205 The provisions of paragraphs (2)(d) and (e) do not apply to
206 policies or certificates issued prior to October 1, 2003.
207 Section 3. This act shall take effect July 1, 2003.
208
209 ================ T I T L E A M E N D M E N T ================
210 Remove the entire title, and insert:
211 A bill to be entitled
212 An act relating to health insurance; amending s. 627.411,
213 F.S.; revising grounds for disapproval of health insurance
214 policy forms that apply certain rating practices or that
215 result in actuarially justified rate increases under
216 certain circumstances; requiring health insurance policies
217 to meet a minimum loss ratio of a specified amount;
218 amending s. 627.6515, F.S.; amending conditions that must
219 be met to exempt from part VII of ch. 627, F.S., a group
220 health insurance policy issued or delivered outside this
221 state under which a resident of this state is provided
222 coverage; providing rulemaking authority; providing an
223 effective date.