CHAPTER 2003-139

Committee Substitute for Committee Substitute for Senate Bill No. 2264

An act relating to health insurance; amending s. 627.411, F.S.; revising grounds for disapproval of health insurance policy forms; requiring health under certain circumstances; amending s. 626.9541, F.S., relating to unfair discrimination; amending s. 627.6515, F.S.; providing for disclosure and exceptions thereto; clarifying applicability to out-of-state group policies; prohibiting predatory pricing; authorizing the Office of Insurance Regulation to adopt rules; clarifying applicability of group conversion provisions; amending s. 641.31, F.S.; specifying nonapplication of certain health maintenance contract filing requirements to certain group health insurance policies; providing exceptions; 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.~~

(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. Paragraph (g) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(g) Unfair discrimination.—

1. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

2. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner whatever.

3. For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but shall not consider whether such condition was caused by an act of abuse. For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;

b. Placing another in fear of imminent serious bodily injury by physical menace;

c. False imprisonment;

d. Physically or sexually abusing a minor child; or

e. An act of domestic violence as defined in s. 741.28.

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination as defined in this paragraph.

Section 3. 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 otherwise 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; 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 must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

"This policy is primarily governed by the laws of ...insert state where the master policy if filed.... As a result, all of the rating laws applicable to policies filed in this state 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." This paragraph applies only to group certificates providing health insurance coverage which require individualized underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual except for the following:

1. 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;

2. 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;

3. Policies 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, and such association is not owned, controlled by, or otherwise associated with the insurance company; or

4. Any accidental death, accidental death and dismemberment, accident-only, vision-only, dental-only, hospital indemnity-only, hospital accident-only, cancer, specified disease, Medicare supplement, products that supplement Medicare, long-term care, or disability income insurance, or similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan, coinsurance, or deductibles or coverage issued as a supplement to workers' compensation or similar insurance, or automobile medical-payment insurance.

(9) Any insured shall be able to terminate membership or affiliation with the group to whom the master policy is issued. An insured that elects to terminate his membership or affiliation with the group shall provide written notice to the insurer. Upon providing the written notice, the member shall be entitled to the rights and options provided by s. 627.6675.

(10) Any pricing structure that results, or is reasonably expected to result, in rate escalations resulting in a death spiral, which is a rate escalation caused by segmenting healthy and unhealthy lives resulting in an ultimate pool of primarily less healthy insureds, is considered a predatory pricing structure and constitutes unfair discrimination as provided in s. 626.9541(1)(g). The Financial Services Commission may adopt rules to define other unfairly discriminatory or predatory health insurance rating practices.

Section 4. Subsection (2) and paragraph (d) of subsection (3) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons. The department, in accordance with generally accepted actuarial practice as applied to

health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(3)

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the department. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. <u>This paragraph does not apply to group health contracts 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 claims costs over the lifetime of the contract due to advancing age or duration is refunded in the premium.</u>

Section 5. This act shall take effect July 1, 2003.

Approved by the Governor June 11, 2003.

Filed in Office Secretary of State June 11, 2003.