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Florida Circuit Court.

Evelyn ADDISON; Benita Axel; Mary Diem; Lorraine Epton; Margee A. Gaudreau; Jack Hodgkin; Joan M. Howell; Barbara MacDonald; Joan M. Potter; Mary I. Rogers; Marcia L. Smith; Renee Thornton; on behalf of themselves and all others similarly situated, Plaintiffs,
v.
AMERICAN MEDICAL SECURITY, a corporation, and United Wisconsin Life Insurance Company, a corporation, Defendants.

No. CL 00-01445 AB.

April 24, 2002.

FINAL JUDGMENT

LABARGA, J.

***1** THIS CAUSE came before the Court for a non-jury trial on the question of liability only on March 4, 5, 6, 7, 11, 12, 13 and 21, 2002. [FN1] After carefully examining and considering all pertinent pleadings and exhibits admitted in evidence, after carefully considering and weighing the testimony presented, and after considering the argument of the attorneys, the Court makes the following findings of fact and legal rulings. [FN2]

FN1. During a hearing on February 1, 2002, counsel for plaintiffs and defendants agreed to bifurcate the issues in this action. Accordingly, the question of liability was tried first.

FN2. This Final Judgment on the question of liability also requires the parties to submit to mediation within fifteen (15) days. *See* p. 28 of this order.

PRELIMINARY MATTERS

This action was brought by the plaintiffs as class representatives on behalf of a class of Florida residents who purchased health insurance from the defendants and who received a cancellation notice dated September 25, 1998.

The plaintiffs' action contains two (2) counts: Breach of Contract (Count I) and Declaratory Relief (Count II).

The plaintiffs contend in their claim for breach of contract that the master insurance policies and individual certificates of coverage issued by the defendants to them incorporate six (6) statutes from the Florida Insurance Code and one administrative rule. It follows then, the argument goes, that any violation of these statutes and rule constitutes a breach of contract.

The defendants counter with the argument that the statutes and administrative rule cited by the plaintiffs are regulatory in nature for which there is no private cause of action and that, in any event, only directly applicable statutes may be read into an insurance policy. Alternatively, the defendants contend that the statutes cited by the plaintiffs were fully complied with and that the Trust and the Taxpayers Network, Inc. were approved by the Department of Insurance as exempt out-of-state groups under § 627.651(2). The plaintiffs, on the other hand, contend that the defendants were not exempt from the requirements of the Florida Insurance Code and that the Department of Insurance did not approve defendants' illegal conduct.

FACTUAL FINDINGS

United Wisconsin Life Insurance Company ("United") was an insurer domiciled in Wisconsin and operating under a certificate of authority to transact the business of insurance in the State of Florida. (Tr. 814:9-12). [FN3]

FN3. References to the trial transcript are designated as "Tr. ____."

In May 1993, United filed the necessary forms and rates with the Florida Department of Insurance, pursuant to § 627.6515(4), *Florida Statutes,* to market an out-of-state group health insurance product. This product, known as "Med One," was offered through an Alabama-sitused dry trust known as "The Prescription for Good Health Trust" (hereinafter "Med One"). Included with the forms filed by United with the Florida Department of Insurance was a Florida State Certificate Rider, which included a statement of conversion rights. A careful examination of the conversion privilege language included in the certificate rider revealed that it failed to comply with § 627.6675; instead it limited the conversion privilege to only the classes enumerated in § 627.6675(14).

According to the evidence presented, the Department of Insurance Bureau of Life and Health Forms and Rates accepted such forms for informational purposes only.

***2** According to the testimony of James Bracher, he was employed by the Florida Department of Insurance for six (6) years. (Tr. 761:16--21). He initially worked in the Bureau of Life and Health Rates and Forms and then became chief of the Bureau of Management Care. (Tr. 762:5--12). Bracher testified that upon comparing the certificate rider filed by United with the 1993 version of § 627.6675, *Florida Statutes,* he discovered that the Department of Insurance made a mistake in accepting it. (Tr. 781: 11--19). According to Bracher, the rider form contained an erroneous statement concerning the conversion rights required by statute. Bracher testified as follows:

> Q. In that forms filing. That's a letter from Mr. Miller, looks like, at the Department saying that the forms are acceptable.
>
> In your experience--and of course you came there in '95. In your experience as the head of the Bureau of Life and Health Forms and Rates, can you explain what acceptable means?
>
> A. I think that the analyst would have found that to the best of his review, these forms did meet those select set of standards that are, or had met, included the select provisions of the statutes that are contained in 627.6515.
>
> Q. And if the analyst looked at that rider which I pulled out of this form file in regard to the conversion privilege, based on your experience as the chief of the Life and Health Bureau of Forms and Rates, didn't he make a mistake?
>
> A. Yes.

(Tr. 780: 24-25--781: 1-16). A revised conversion certificate rider to the "Med One" product was never issued.

Because the "Med One" product was issued to a group formed primarily for the purpose of selling group insurance pursuant to § 627.651(2)(a), *Florida Statutes,* the defendants were required to demonstrate to the Department of Insurance that the rates charged for such coverage were reasonable in relation to the benefits offered, and that the rates justified the benefits offered. Given this requirement, the defendants submitted their "Med One" rates to the Florida Department of Insurance for consideration. Upon reviewing the proposed rates and upon further inquiry, the Department of Insurance learned that the defendants re-underwrote each insured individually on an annual basis from 1993 until 1997 based on their health status and claim history. [FN4] The Department of Insurance disapproved this filing because it violated Florida law and ordered the defendants to cease and desist from such conduct.

> FN4. This process was referred to as "tier rating." According to the testimony presented, "tier rating" is a renewal rating methodology in which an insured's claim history/health status related factors are considered in determining the amount of premium to charge. Tr. 344:20--355: 14; 1289:11--1298:1.

In November 1996, United filed with the Florida Department of Insurance, pursuant to § 627.6515, *Florida Satues,* the necessary documents to market a different out-of-state group health insurance product called "Med One Choice." In this instance, United offered the product through an Ohio based association called Taxpayers Network, Inc. ("TNI"), formed primarily for purposes other than providing insurance.

Given United's decision to market its new "Med One Choice" product, Timothy Moore, General Counsel for the defendants, testified that on September 22, 1998, he informed the Florida Department of Insurance that the "Med One" product was going to be discontinued in Florida in its entirety as to each insured as of the 1999 renewal date. (Def. Exh. 1; Pl. Exh. 25; Tr. 1396:22-- 1397:12; 1397:21--1398:3, 1398:6--10). Accordingly, on September 25, 1999, the defendants sent a letter to each insured informing them of said decision. (Pl.Exh. 205). The defendants guaranteed that the insureds would be issued coverage under a "Med One Choice" plan called the "Classic Benefit Plan"--the defendants' highest rated plan. (Pl.Exh. 69). The defendants also assured the Florida Department of Insurance that they would not use the "tier rating" practice in determining the premium to charge for the "Med One Choice" product.

***3** In explaining these changes, the defendants asserted in communications to their insureds, their agents, as well as the Florida Department of Insurance, that these steps were being taken in order for them to remain competitive and to simplify their administration. They added that the only way they could continue to do business in Florida was to take these steps. (Pl. Exh. 15, batcs # 03495; Pl. Exh. 46).

The insureds were required to submit an application to "join" TNI and were required to pay a $5.00 monthly membership fee. (Pl.Ex. 69). The defendants

also invited the insureds to apply for other "Med One Choice" plans.

Upon learning of the decision to close down the "Med One" product, the Department of Insurance, concerned about the insureds, questioned the defendants about whether the closing of the program would cause a "death spiral" of the product. The defendants, however, assured the Department of Insurance that after a period of three (3) years, they would be able to pool the resources of the "Med One" insureds with the resources of the "Med One Choice" insureds to prevent such a situation from occurring.

TNI, according to the evidence presented, is an independent association formed in 1992 as a 501(c)(4) tax exempt organization for purposes of educating the public on tax and public policy issues. (Tr. 1375:18--1376:1); *See also* Def. Exh. 82. Since its inception in 1992, according to the evidence presented, TNI has published newsletters, given monthly briefings at citizen group meetings, distributed booklets and reports, distributed advisory petitions, established a wholesale website, and has made radio and television appearances. (Def.Exh. 82). Forty-eight (48) different insurance plans are offered to members of TNI. (Def. Exh. 36; Tr. 1248: 5--7).

In making their application for the "Med One Choice" plan with the Department of Insurance, the defendants submitted the necessary forms and rates, including the identical certificate rider pertaining to conversion rights submitted in 1993. In this instance, however, the analyst for the Department of Insurance informed the defendants that the certificate rider did not comply with the requirements of § 627.6675, *Florida Statutes*. The Department of Insurance instructed the defendants to revise the certificate rider to conform with the requirements of the statute. *See* Defense Exhibit 45B, bates # 94--96.

According to the defendants, beginning on February 1, 1997, United adopted "block rating," a renewal rating methodology in which a certificate holder's risk factor did not change, and no consideration was given to the certificate holder's health status or claims history upon renewal. Under block rating, all insureds receive the same premium increase at renewal. (Pl.Exh. 58, ¶ 1). However, despite said assertion, the plaintiffs presented evidence of at least one "Med One" insured whose premiums were raised based on the "tier rating" approach after the defendants had supposedly ceased such practice. (Pl.Exh. # 54).

***4** The Florida Legislature, during its 1997 session, passed Session Law 97- 197 which included a revision to § 627.6675, *Florida Statutes*. The effect of the revision was that it broadened the time for notification by an insured for conversion from thirty-one (31) days to sixty-three (63) days. Such statutory revision went into effect in January of 1998 and was to apply to every insurance certificate issued or renewed after the effective date of such statute.

According to James Bracher, within one (1) month after the legislative session ended (approximately July, 1997), he sent a memorandum to each insurer affected by the statutory change which advised the insurer of the effective date of the impending statutory change. This memorandum, according to Mr. Bracher, was sent as quickly as possible in order to afford each such insurer more than adequate time to review and revise their forms accordingly. Despite Bracher's early warning, the defendants did not submit a revised certificate rider form to the Florida Department of Insurance until December, 1998--almost one (1) year after the effective date of the revised statute. (Def.Exh. 48G). In fact, according to the evidence presented, the defendants did not even take the necessary internal steps to revise the forms until April, 1999. (Pl.Exh. 148). The revised forms were ultimately sent to their insureds sometime in October of 2000. (Pl.Exh. 63).

After considering and weighing the testimony presented, the Court finds that the defendants failed to provide a reasonable explanation as to why it took them over three (3) years to implement the statutorily mandated change in the forms. In fact, according to the evidence presented, none of the class members in this action had a certificate rider which gave them sixty-three (63) days to convert in 1998 or 1999.

The defendants, internally and in communication to the Florida Department of Insurance, asserted that they intended to give each insured a "required" 90-day notice of discontinuance of the Med One product. (Pl. Exhibits 25, 67 & 177). However, when questioned about it during testimony, the representatives for the defendants were not able to clearly explain the source of the 90-day "requirement." The Court received in evidence two (2) documents which clearly noted that the defendants recognized internally that they were bound by, and subject to, the provisions of § 627.6425. In fact, one such internal document quotes the pertinent portions of the statute verbatim. (Pl.Exh. 191).

Despite their claims to the contrary, the more credible evidence revealed that the defendants, in re-underwriting the insureds' policies, limited the options available to "Med One" insureds both by refusing to offer them the plan of their choice and by setting the premium price based on health status. (Pl.Exh. 239). After receiving numerous complaints from "Med One" certificate consumers, the Florida Department of Insurance asked the defendants about their premium rates. The defendants refused to provide such information to the Department of Insurance based on their assertion that the Department had no right to see their rates because the Taxpayers Network was a group formed for purposes other than providing insurance. (Pl.Exh. 68).

***5** Ultimately, United met with a representative of the Department of Insurance (Bracher) and entered into an agreement with the Department to offer certificate holders an additional guaranteed TNI plan and to cap the rate for the guaranteed plans at no more than twice the rate currently being paid for the discontinued "Med One" plan. (Pl. Exh. 46; Tr. 802:6--24, 827:12--828:7, 1250:22 1251:5, 1406:11--18). Based upon United's guarantee, the Department of Insurance approved the discontinuance. Thereafter, in accordance with the approved plan of discontinuance, on or about January 19, 1999, United notified the certificate holders of the additional guaranteed issue option available to them. (Pl.Exh. 206, Tr. 1251:6--24, 1405:8--1406:10).

According to Bracher's testimony, however, had he known that the defendants intended to recommence "tier rating," he would have never entered into such an agreement with them. Clearly, had the defendants released their rate information to the Department of Insurance when requested, Bracher may have been in a position to discover such rating practice before their meeting. Moreover, Suzanne Murphy, the Deputy Commissioner of Insurance at the time, testified that neither Bracher, nor she, nor the Department of Insurance in its entirety, had the authority to permit the defendants to waive, be excused from, or make an agreement in contradiction to the clear requirements of Florida law.

According to the more credible evidence presented, sometime in October, 1999, the defendants, without informing the Department of Insurance, unilaterally decided to begin to medically re-underwrite at the time of renewal the "Med One Choice" insureds again. Given that the defendants considered the insureds' health in re-underwriting them, they were once again using the previously disallowed "tier rating" system. (Pl.Exh. 72).

During the trial, the plaintiffs presented the testimony of several class members and two (2) experienced health insurance agents. The agents testified that the "Med One" policies included a certificate rider which contained the misleading language limiting conversion rights to death of a spouse, end of marriage, or loss of dependant status.

Of the 11,861 "Med One" insureds who received the September 25, 1998 notice letter, only approximately 4,500 became "Med One Choice" insureds. Of these individuals, only approximately 1,900 are so insured today. The defendants suggested during trial that the remaining class members either obtained insurance elsewhere or became Medicare eligible. They further suggested that their "tier rating" system actually benefited some of the 11,861 "Med One" certificate holders. The defendants, however, did not present any evidence to support such assertions.

The recommenced tier rating system has resulted in staggering premium increases for some of the members of plaintiffs' class. One noteworthy example is Roberta Sands. Ms. Sands, a 64 year-old woman suffering with diabetes and wearing a pacemaker, saw her premiums skyrocket beyond comprehension. Ms. Sands' premium payments for the "Med One" product in 1993 was approximately $253.00 per month. According to the evidence presented by plaintiffs, her renewal quote from the defendants was approximately $4,800.00 per month, or $56,000.00 per year. Ms. Sands' case belies the testimony of James Modaff, actuary for the defendants, that the lifetime premium increase for their insureds would be capped at 500%. Clearly, had Ms. Sands obtained a conversion policy, she would have saved approximately $45,000.00 in premiums.

I. *GROUP INSURANCE*

***6** Much of the dispute in this action centers around the purpose and principles that govern group health insurance. The primary purpose of group health insurance is to spread and share the risk among a group of insureds. Typically, a group policy is issued to a policyholder and the individual insureds are issued certificates of insurance rather than individual policies. (Pl. Exh. 215 and 217).

The working principle behind the group health insurance concept is that the risk is spread by pooling

the risks according to what is sometimes referred to as the "law of large numbers." According to the "law of large numbers," people within the group pay premiums based on factors irrespective of whether or not they are healthy or whether or not they make claims. If the carrier decides to raise premiums, it must do so for the entire group and not single out individuals based on their health status or claims history.

Clearly, a health insurance company has the right to obtain necessary information from an individual applying to become a member of the group in order to set a reasonable premium. For this reason, health insurance carriers have underwriting and actuarial departments. Nevertheless, once a person becomes a member of the group, the carrier cannot raise rates. As noted by Tim Ryles, the former Commissioner of Insurance for the State of Georgia, the ongoing underwriting of a group must be based on the experiences of the group, and not on the claim history of any particular insured; otherwise, there would virtually be no difference between a group policy and an individual policy.

According to the more persuasive evidence presented during the trial, the defendants in the instant action engaged in annual re-underwriting "tier rating" in 1993 through 1997 and from 1999 until the present time. Under this system, *individual* insureds were re-underwritten each year. Those who developed medical problems were placed in substandard tiers as opposed to standard and preferred tiers. To make matters worse, their premiums were raised as much as 37% according to James Modaff, and as much as 60% according to Thomas Wise and George Bernstein. (Pl. Exhibits 210, 211, 214 and 251). In contrast, insureds who had not made many claims experienced either no premium increase or at best an increase of 5%.

James Modaff, the defendants' chief actuary, suggested that the "tier rating" system is necessary in order to keep the premium rates of "healthy insureds" from increasing at the same rate as the "sick insureds." He further suggested that such a system is necessary in order to keep healthy insureds in the group. Thus, under this rationale, an insured who pays premiums for twenty very healthy years will find his or her rates increasing quite dramatically if he or she ever begins to get sick and actually need insurance! Given the unfairness of such practice, it should come as no surprise that Mr. Modaff testified that no other group health insurer in the State of Florida uses "tier rating" to determine premium increases after the master policy is sold and the certificate holders become part of a group.

***7** Such conduct defics the purpose of group health insurance, especially as contemplated by the Florida Legislature. Moreover, Florida law prohibits the re-underwriting of individuals who are already members of a health insurance group based on their individual health status. This is one of the very important protections given to insureds by Florida law. As aptly noted by Carmen Rodriguez, an agent for the defendants, in a letter to the Department of Insurance:

> It seems wrong that if you qualify for a plan at the inception, paid your premiums as indicated by the contract, that when you become ill and use your insurance, that the carrier takes the position to alter the coverage in midstream and surprises you with a sudden death sentence with unaffordable premiums almost to get rid of you.

(Pl.Exh, 235).

According to the testimony of Frank Dino, the chief actuary for the Florida Department of Insurance, the defendants' "tier rating" practice was disapproved in 1996. The following exchange took place during his trial testimony:

> Q. So what they were doing--I'm sorry.
> A. And the review of the filing took issue with that practice of moving insureds between tiers at time of renewal, and we ultimately disapproved the filing for that practice.
> Q. So what they were doing in 1996 were they were renewing everybody based upon their claims history and health status for the prior year?
> A. That is what was proposed. At the time we had no knowledge whether or not the company was actually doing that. This was the first filing that I was aware of that they indicated they intended to do that, and we said that you would not be able to.
> Q. So you are not telling us that they didn't do it before, you just didn't know about it, correct?
> A. That's correct.
> Q. And what did you ultimately do as the Department of Insurance for the State of Florida with respect to that 1996 filing that contained the tier- rating?
> A. The filing that contained the reference of moving insureds between tiers was disapproved.

(Tr. 671:11--672:7).

In fact, Mr. Dino added that the defendants were told during various communications that their proposal violated Florida law. (Tr. 672:8--24). They were told that medically re-underwriting group insureds upon

renewal would be a violation of Florida law.

II. *VIOLATION OF APPLICABLE STATUTES IS TANTAMOUNT TO A BREACH OF THE INSURANCE CONTRACT*

It is settled law in Florida that applicable insurance statutes are incorporated into every insurance policy. The Florida Supreme Court in *Grant v. State Farm Fire and Cas. Co.*, 638 So.2d 936 (Fla.1994), held:

> ... where a contract of insurance is entered into on matters surrounded by statutory limitations and requirements, the parties are presumed to have entered in such agreement with reference to the statute, and the statutory provisions become a part of the contract.

See also State Farm Fire & Cas. Co. v. Palma, 629 So.2d 830, 832 (Fla.1993) (The terms of § 627.428 are an implicit part of every insurance policy in Florida); *Weldon v. All American Life Ins. Co.*, 605 So.2d 911, 914 (Fla. 2d DCA 1992) (Where a contract of insurance is entered into on a matter surrounded by statutory limitations and requirements, the parties are presumed to have entered into such agreement with the reference to the statute and the statutory provisions become a part of the contract); *State Farm v. Swearingen*, 590 So.2d 506, 507 (Fla. 4 th DCA 1991) (Section 627.418(1) [the med. pay statute], specifically states that any insurance policy which contains any condition or provision not in compliance with the requirements of the insurance code shall be construed and applied as if the policy had been in full compliance with the code); *United States Fire Ins. Co. v. Van Iderstyne*, 347 So.2d 672, 673 (Fla. 4th DCA 1977) (Where the policy is not in conformance with the statute, the court writes into the policy a provision to comply with the law); *Standard Marine Insurance Company v. Allyn*, 333 So.2d 497 (Fla. 1st DCA 1976), *cert. dism.*, 196 So.2d 440 (Fla.1967); *Allison v. Imperial Casualty and Indemnity Company*, 222 So.2d 254, 256 (Fla. 4th DCA 1969).

***8** Given the principles enunciated in the aforesaid authority, Florida courts have consistently held that insureds may bring, *inter alia*, a breach of contract action when an insurer violates statutory provisions which are deemed incorporated into the insurance policy. *Standard Marine Insurance Company v. Allyn*, 333 So.2d 497 (Fla. 1st DCA 1976); *United States Fire Ins. Co. v. Van Iderstyne*, 347 So.2d 672 (Fla. 4 th DCA 1977); *Weldon v. All American Life Ins. Co.*, 605 So.2d 911 (Fla.1992); *Auto Owners v. DeJohn*, 640 So.2d 158 (Fla. 5th DCA 1994).

III. *EXEMPTION FROM PART VII OF FLORIDA INSURANCE CODE*

Florida law permits an out-of-state insurer to be exempt from the bulk of Part VII of the Florida Insurance Code if it complies with certain mandatory provisions of § 627.6515(2), Florida Statutes. Section 627.6515(2) provides that except for certain specifically enumerated provisions, Part VII of Chapter 627 does not apply to a group health insurance policy issued or delivered outside of Florida covering a Florida resident if certain requirements are met. Section 627.6515(2) provides:

> (2)(a) The policy is issued to ... an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; ... [or] a group that is established primarily for the purpose of providing group insurance ...;
>
> (b) Certificates ... contain ... 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.

There was no dispute during the trial that the defendants complied with the requirements of § 627.6515(2)(b) by basically putting the appropriate stamp on the various "Med One" and "Med One Choice" certificates. There was, however, a great deal of controversy about whether the defendants complied with the mandatory provisions of § 627.6515(2)(a) and (c). The plaintiffs challenge the Department of Insurance's determination that the trust satisfied the criteria of § 627.6515(2)(a) and (c) for two reasons: (1) the Alabama "dry trust" was not a valid trust under Alabama law; and (2) the trust coverage did not provide the "benefits" specified in § 627.6675 (the conversion statute), one of the twelve (12) listed statutes in subsection (c), because the notice of conversion privilege contained in the certificate of coverage failed to fully and accurately notify insureds of their conversion privilege.

a) § 627.6515(2)(a)

Under § 627.6515(a), a group policy may be issued to "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." The trust was accepted by the Department of Insurance as such a group.

***9** The defendants contend that the validity of the trust under Alabama law has no bearing on its compliance with § 627.6515 because it was a group formed primarily for the purpose of providing group insurance; consequently, the trust policy issued by United complied with § 627.6515(2)(a). The plaintiffs, on the other hand, contend that the trust itself had to be a valid trust before the group could be considered valid pursuant to § 627.6515(2)(a). *See Coosa River Water, Sewer and Fire Protection Auth. v. South Trust Bank,* 611 So.2d 1058 (Ala.1993).

The Court finds that the defendants did not submit any evidence or law to show that a "dry trust" is a valid trust. The Court agrees with the plaintiffs' contention that the trust itself must be a valid trust before the group may be regarded as valid pursuant to Florida law.

In considering the evidence presented, the Court examined numerous corporate documents, as well as correspondence between the defendants and the Florida Department of Insurance in regard to the formation, control, activities and membership of the Taxpayers Network. The Taxpayers Network is a group which purports to be formed primarily for purposes other than providing insurance pursuant to § 627.6515(2)(a). However, a close examination of its practices disclosed that the group had no members whatsoever from 1992 to the beginning of 1996. (Def. Exh. 45B, bates 146, 151, and 206). In fact, according to the evidence presented, defendant American Medical Security ("AMS") entered into an administrative services agreement with Taxpayers Network in 1996. (Pl.Exh. 75). In 1996, defendant AMS designed and obtained a benefits package through a third party vendor for Taxpayers Network members. According to the testimony of Timothy J. Moore, he served on the board of directors and as corporate secretary of the Taxpayers Network group despite the fact that he was general counsel for defendant AMS. The board of trustees meetings of Taxpayers Network were held at AMS headquarters. (Pl. Exhibits 103 and 112).

In fact, it was not until the defendants filed forms and rates for informational purposes to market and sell the "Med One Choice" product with the Florida Department of Insurance that the Taxpayers Network even have enrollees. Even then, the number of enrollees were limited to approximately 30 or 35 beginning in August of 1996. [FN5] (Def. Exh. 45B, bates # 215 217).

> FN5. Contrary to these findings, Michael Riley, the founder of the Taxpayer Network, wrote to the Florida Department of Insurance in 1999 and represented that the membership of the group was in the thousands during 1995 and 1996 (Pl.Exh. 79) when the Taxpayers Network corporate documents indicated no members at all.

Accordingly, based on the more persuasive evidence presented, the Court finds that the Taxpayers Network was a group formed for purposes of group insurance. As such, the defendants were required to show, even if exempt from Part VII, pursuant to § 627.6515(2)(a) , that the Taxpayers Network rates were reasonable in relation to the benefits offered. Further, the defendants were not permitted to use the "tier rating" practice more fully described earlier in this order.

(b) § 627.6515(2)(c)

As noted above, § 627.6515(2)(c) requires that "the policy provides the benefits specified" in twelve (12) other provisions of the Florida Insurance Code. Included in the enumerated statutory provisions are the following:

***10** (1) Section 627.419--- a statute dealing with construction of policies.
(2) Section 627.6575--a statute requiring coverage for newborn children.
(3) Section 627.6612--a statute requiring coverage for surgical procedures and devices used in mastectomy.
(4) Section 627.667--- a statute which requires an extension of benefits in the event of total disability of a certificate holder.
(5) Section 627.6675--the statute which was the central issue of this action.

In considering whether the defendants complied with § 627.6675, the Court considered the 1993 and 1998 versions of the statute. Each version requires, in pertinent part, that any member whose insurance coverage under a group policy has been terminated for any reason, including discontinuance of the group policy in its entirety, shall be entitled to have issued to them a converted policy. The premium for such converted policy cannot exceed 200% of the standard risk rate as established by the Florida Department of

Insurance.

The only exception to the requirement that a member be afforded a converted policy under such circumstances is "[b]ecause any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance." *See* § 627.6675. The defendants contend that since all "Med One" insureds were "eligible" for the "Med One Choice" product, the exception set forth in § 627.6675 applies; thus, the "Med One" insureds were not entitled to a converted policy. The evidence, however, was unequivocal that the defendants did not discontinue the "Med One" product because it was replaced by the "Med One Choice" product.

According to the evidence presented members of the plaintiffs' class were not informed of their conversion rights as required by § 627.6675. In fact, many members with certificates issued prior to November of 1996 had certificates that grossly misrepresented their conversion rights by limiting such rights to circumstances where their marriage ended, they were widowed or they were no longer an eligible dependant.

The defendants contend, however, that even if the certificates provided the insureds with incorrect information about their conversion rights, they were still within the requirements of § 627.6675 because they were only required under §§ 627.6515(2)(c) and 627.6675(17) to notify them of the privilege, as long as the benefits would be provided upon request. Thus, according to this interpretation, the burden was on insureds to request benefits they may not have known even existed.

The defendants' interpretation is without merit since § 627.6675 clearly requires that group health insurance carriers provide the option of a converted policy to insureds when insurers terminate a policy "for any reason." Given that mandatory statutory requirement, an insurance company may not misrepresent conversion rights afforded to insureds by law in the certificate. Further, given the clear language of § 627.6675, it could not have been the intention of the Florida Legislature to permit group health insurance carriers to shift the burden to insureds to make the necessary inquiries about their rights. Accordingly, the Court finds that the conversion certificate rider submitted by the defendants to their insureds did *not* comply with the strict requirements of § 627.6675. Since compliance with § 627.6675 was mandatory in order for the defendants to be exempt from the requirements of Part VII of the Florida Insurance Code, the defendants were *not* exempt and all provisions of Part VII are applicable against them.

IV. *Section 627.6425, Florida Statutes*

***11** It should be noted from the beginning that § 627.6425, *Florida Statutes*, is contained in Part VI of the Florida Insurance Code, not Part VII. Thus, even if the defendants had properly complied with the mandatory provisions of § 627.6515(2) in order to be exempt from the requirements of Part VII, they would still need to comply with Part VI.

Section 627.6425(3)(a), *Florida Statutes*, provides:

> In any case in which an insurer decides to discontinue offering a particular policy form for health insurance coverage offered in the individual market, coverage under such form may be discontinued by the insurer *only if:*
>
> 1. The *insurer* provides notice to each covered individual provided coverage under this policy form in the individual market of such discontinuation at least 90 days prior to the date of the non-renewal of such coverage;
>
> 2. The insurer offers to each individual in the individual market provided under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and
>
> 3. In exercising the option to discontinue coverage of this policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage. (emphasis added).

Section 627.6425(1) defines health insurance coverage by referring to § 627.6561(5)(a)(2) which provides the following definition:

> "Health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan, contract health maintenance contract offered by a health insurance issuer.

Given said definition, the Court finds that § 627.6425 applies to the defendants and that they are required to

comply with the statute.

The plaintiffs claim that the provisions of § 627.6425 require an insurance company that has decided to discontinue a particular form of health insurance, to offer to its insureds "any other" individual health insurance coverage currently being offered by the insurer. It also requires the insurer to act uniformly and without regard to any health status related factor in determining the relevant coverage options.

The defendants, on the other hand, contend that they fully complied with § 627.6425 because they offered the insureds a classic benefit plan, or a "most similar plan." In arriving at that conclusion, the defendants interpreted the words "any other" in § 627.6425(3)(a) 2 to mean that they only have to offer the insureds one of the various plans currently offered without regard to health status. They further maintain that the statute does not prohibit increases in premium due to health-status-related factors, regardless of the amount of the increase. Thus, because they have offered each certificate holder the option to purchase a plan without consideration to health status, the defendants contend that they have complied with the law. The Court respectfully disagrees.

***12** It is an established principle that where the language of a statute is clear and unambiguous and conveys clear and definite meaning, there is no occasion for resorting to the rules of statutory interpretation and construction; the statute must be given its plain and obvious meaning. *A.R. Douglass, Inc. v. McRainey,* 137 So. 157 (Fla.1931); *Holly v. Auld,* 450 So.2d 217 (Fla.1984); *Winter v. Playa del Sol, Inc.,* 353 So.2d 598 (Fla. 4th DCA 1977); *Opperman v. Nationwide Mut. Fire Ins. Co.,* 515 So.2d 263 (Fla. 5th DCA 1987); *Blum v. Tamarac Fairways Ass'n, Inc.,* 684 So.2d 826 (Fla. 4th DCA 1996); *Tallahassee Memorial Regional Medical Center, Inc. v. Tallahassee Medical Center, Inc.,* 681 So.2d 826 (Fla. 1st DCA 1996); *State v. Cohen,* 696 So.2d 435 (Fla. 4th DCA 1997); *Bolden v. State Farm Auto. Ins. Co.,* 689 So.2d 339 (Fla. 4th DCA 1997).

Absent an ambiguity, the statute's plain meaning prevails and will not be disturbed. *Id.* The "plain meaning" rule provides that the statute itself must be given its plain and obvious meaning. *Blum v. Tamarac Fairways Ass'n, Inc.,* 684 So.2d 826, 828 (Fla. 4th DCA 1996). No further inquiry is required unless an unreasonable or ridiculous conclusion would result from a failure to do so. *Mike Smith Pontiac, GMC, Inc. v. Mercedez-Benz of North America, Inc.,* 32 F.3d 528 (11th Cir.1994). In fact, courts of this state are without authority to construe and unambiguous statute in a way which would extend, modify, or limit its express terms or its reasonable and obvious implications. *Holly v. Auld,* 450 So.2d 217 (Fla.1984) . To do so would be an abrogation of legislative power. *Id.*

In *Auto-Owners Ins. Co. v. Conquest,* 658 So.2d 928, 929 (Fla.1995), in considering statutory language very similar to the "any other" language used in § 627.6425(3)(a)2, the Florida Supreme Court noted that "it has a long history of giving deference to a statute's clear and unambiguous wording." The issue in *Auto-Owners* was whether third parties were to be considered within the definition of "any person" under § 624.155, Florida Statutes, in order to be permitted to seek relief for statutory unfair claims settlement practices. The Florida Supreme Court held:

> We find the section's use of the words "any person" dispositive. The words are precise and their meaning unequivocal. By choosing this wording the legislature has evidenced its desire that all persons be allowed to bring civil suit when they have been damaged by enumerated acts of the insurer.

Id. at 929. Likewise, by failing to offer "any other" of the "Med One Choice" plans uniformly without regard to health status in the instant action, the defendants failed to comply with the mandate of § 627.6425.

Nor is the Court persuaded, as suggested by the defendants, that because the word "pricing" is not included in § 627.6425, they are free to increase premiums based on an insured's health status and claim history. Reduced to its simplest, the language and clear intent of § 627.6425 is to afford out-of- state insurance companies the opportunity to do business in the State of Florida as long as they do not medically re-underwrite and raise premiums for replacement policies based on health status and claims history.

***13** The Court does not interpret "any other" as restrictive to one or two specific plans. The use of the words "any other" in this context can only be interpreted to mean that the insurer must afford each insured member the opportunity to choose from any of its plans.

V. *Approval by the Department of Insurance*

The defendants also contend that the Florida Department of Insurance approved their activities. They interpreted the acceptance by an analyst with the

Department of Insurance of their certificate conversion rider form in 1993 as a finding by the Department that their form complied with Florida law. Such a position, however, is not supported by the clear and unambiguous language of § 624.414, Florida Statutes, which provides, in pertinent part, as follows:

> The certificate, if issued, shall specify the kind(s) and the line(s) of insurance the insurer is authorized to transact in this state. The issuance of a Certificate of Authority does not signify that an insurer has met the requirements of this code relative to the filing and approval of an insured's policy forms, riders, endorsements, applications, and rates, which may be required prior to an insurer actually writing any premiums.

Thus, the legislature did not intend for the mere acceptance of the rider form by the Department of Insurance to mean that the defendants have met all of the requirements of the statute.

Florida courts have considered the question of whether a deviation from the explicit terms of statutory requirements may be excused because the Department of Insurance accepted the forms. In *Gonzalez v. Associated Life Insurance Company,* 641 So.2d 895 (Fla. 3d DCA 1994), the Third District Court of Appeal noted in footnote # 1:

> Associates Life argues that because the Department of Insurance pre-approved the form of policy issued here, we should affirm. Regardless of what deference we should accord to the Department's determination, we find that as a matter of law, its approval of the policy form in this case was clearly erroneous, and that reversal is required.

See also, Kaufman v. Mutual of Omaha Insurance Company, 681 So.2d 747 (Fla. 3d DCA 1996).

James Bracher, the former chief of the Bureau of Life and Health Forms and Rates of the Florida Department of Insurance, testified that the Bureau receives over 13,000 form filings per year. These filings were typically reviewed by seven (7) or eight (8) persons. Given the number of filings, he testified that the Department of Insurance would normally accept the filings and rely on the insurers' certification that the filings complied with Florida law.

In reviewing the certificate rider issued by the defendants, Mr. Bracher testified that it did not comport with the provisions of § 627.6675. According to Mr. Bracher, the defendants, as insurers permitted to do business in the State of Florida, had an ongoing duty to monitor and ensure that their forms complied with statutory mandates.

***14** In fact, in 1996 the Department of Insurance informed the defendants to revise their certificate rider to conform with the requirements of § 627.6675. According to the uncontradicted evidence presented during the trial, the defendants never revised their form to comply with Florida law for any of the class members.

Given these findings, the Court finds that the Florida Department of Insurance did *not* approve the defendants' conduct.

Furthermore, the defendants assured the Department of Insurance that they would stop "tier rating" after being instructed to do so by the Department. Nevertheless, according to the testimony of James Modaff, the defendants' chief actuary, he suggested that they could "tier rate" again. Thereafter, without consultation with the Florida Department of Insurance, the defendants reinstated that practice again.

Finally, the defendants contend that the Court should not "second guess" the acceptance by the Department of Insurance. Such a position, however, could only be properly considered if the Department's determination had itself been in compliance with Florida law. As more fully discussed above, it clearly was not. *See Equity Corporation Holding, Inc. v. Department of Banking and Finance,* 772 So.2d 588 (Fla. 1st DCA 2000); *Werner v. State Department of Insurance and Treasurer,* 689 So.2d 1211 (Fla. 1st DCA 1997); *Las Olas Tower Company v. City of Fort Lauderdale,* 742 So.2d 308 (Fla. 4th DCA 1999).

VI. *Effect of Inapplicability of Exemptions*

Given the violations of strict Florida law by the defendants in this action, they have lost their exemption to Part VII of the Florida Insurance Code. Consequently, the defendants are subject to all provisions of Part VII, including, *inter alia,* § 627.65625, which prohibits discrimination against individual participants and beneficiaries based on health status; § 627.640, incorporated into Part VII by § 627.662, which requires the defendants to file their premium rates with the Florida Department of Insurance; § 627.410, which requires the defendants to obtain ongoing approval of their forms and notes; as well as F.A. C., Chapt. 4--149, regarding forms and rate filings.

Finally, the defendants contend that §§ 627.6692 and

627.6699, *Florida Statutes*, apply only to small group insurance market. There was evidence presented that these statutes apply to groups as small as one, i.e., self- employed individuals. The question of whether any members of the class in this action were self-employed shall be considered during the damages phase of this action.

Accordingly, given the aforesaid findings and legal rulings, it is hereby

ORDERED AND ADJUDGED as follows:

1) The Court finds in favor of the plaintiffs on the question of liability.

2) The question of damages shall be considered before a jury in accordance with the Court's schedule.

3) The Court reserves jurisdiction to take any further action it deems proper in this action. The Court also reserves jurisdiction to consider the question of entitlement and, if applicable, the reasonable amount attorney's fees and costs.

MEDIATION

***15** Within fifteen (15) days of the date of this order, the parties shall submit to mediation on the question of *damages* and any other issue in this action including, but not limited to, the question of attorney's fees and costs.

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END OF DOCUMENT