SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1576

SPONSOR: Banking and Insurance Committee and Senator Meek

SUBJECT: Health Insurance (Rate Filing Requirements)

DATE: April 13, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.			FP	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 1556 makes various changes to the laws that apply to health insurance rates, ss. 627.410 and 627.411, F.S. In general, these changes allow for certain rating practices that are currently prohibited; specify certain rate standards and requirements in place of broader department discretion to disapprove a rate filing; provide greater freedom for an insurer to establish separate, segregated groups of policy forms for which claims experience and rates would be based, rather than being required to merge the experience of all similar policy forms; exempts "unique" rate filings for group policies covering 51 or more persons if the policyholder agrees to the rate; and revises the requirements for insurers that elect to use a loss-ratio guaranty as a method for a rate filing to be deemed approved.

More specifically, the bill makes the following changes:

- Deletes the current grounds for disapproval of a health insurance policy form or rate filing that "contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." The bill retains the requirement that benefits must be reasonable in relation to the premium charged, but deletes the authority of the department to make this determination based on certain specified factors. Instead, the bill specifies loss ratio requirements that must be met, which are similar to the minimum loss ratio requirements that are established in the current rules adopted by the department

- Deletes the current law that prohibits an insurer from filing a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department that it is discontinuing the availability of a policy form.

- Deletes the current requirement that the claims experience of all policy forms providing similar benefits be combined for all rating purposes. As revised, the insurer would be required

to combine the experience of an individual health insurance policy form that is no longer being marketed in Florida with the experience of *at least one other* individual policy form, providing similar benefits, *as determined by the insurer*, which is still being marketed in the state.

- Exempts from the rate filing requirements group health insurance policies if the policy forms to which the rate applies are of "unique character" for benefits under group health insurance policies insuring 51 or more persons and the rates are used at the request of the individual policyholder or certificateholder.

- Amends the loss ratio guarantee provisions, under which the insurer guarantees that its policies will meet certain required minimum loss ratios and to give policyholders a refund if the minimum loss ratio is not met. If the insurer has less than 500 policyholders in the state, the current law requires that the insurer use its nationwide loss ratio. Under the bill, if the insurer has less than 500 policyholders in the state and less than 2,000 policyholders years nationwide, the experience must be accumulated until the end of the calendar year in which 2,000 policyholder years are obtained.

By providing greater freedom for health insurers to establish and change rates for policies issued in Florida, the bill is likely to result in a greater degree of rate increases, particularly for persons who have health conditions that make them ineligible for a new policy if their current policy becomes unaffordable. However, it may encourage more insurers to sell insurance in the state and may result in lower rates, at least initially, for persons who do not experience serious health problems.

The bill substantially amends the following sections of the Florida Statutes: 627.410 and 627.411.

II. Present Situation:

Heatlh Insurance Rate Filing Requirements, Generally

Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance pursuant to sections 627.410 and 627.411, F.S. Rates must be filed at least 30 days prior to use and the department may initiate proceedings to disapprove the rate within this 30-day period, or within an additional 15-days if extended by the department. The filing is deemed approved at the end of such period if it is not disapproved by the department. These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies. Separate requirements are established in chapter 641, F.S. for health maintenance organizations contracts.

The primary grounds for disapproval for health insurance rates are if the policy "provides benefits which are unreasonable in relation to the premium charged, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." [s. 627.411(1)(e), F.S.]

Health Insurance Rate Filing Rules by the Department of Insurance

The Department of Insurance is authorized to adopt rules for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates, and may exempt policy forms. [s. 627.410(6)(b), F.S.] The department has adopted rules pursuant to this authority which establish minimum loss ratio requirements for all types of health insurance policy forms. (4-149, F.A.C.) A *loss ratio* is expressed as the percentage of the premiums that the insurer is required to pay in benefits. So, a minimum 65 percent loss ratio requires an insurer to set its rates so that at least 65 percent of the premium is paid in benefits and that no more than 35 percent is for expenses and profit. The minimum loss ratio requirements vary for different types of policy forms and generally range from 55 percent to 75 percent. For example, the rule establishes a minimum 65 percent loss ratio for individual health insurance policies that are guaranteed renewable and also for small group policies (1 to 50 certificates); 70 percent for group policies with 51-500 certificates; and 75 percent for group policies with greater than 500 certificates.

For over a year, the department has attempted to revise their health insurance rating rules which are currently subject to a legal challenge, with an administrative hearing pending. One of the issues addressed in the proposed rules, not addressed in the current rule, is a definition of "viable" as used in the current statute that allows the department to disapprove a premium increase that is "not viable for the policyholder market." The current proposed rule language specifies that this prohibits: 1) an ultimate premium after the increase that is not within the range of rates actually being charged by other companies for comparable coverage, excluding the highest and lowest rate in the market; 2) more than one premium increase to the affected insureds over a 12-month period; 3) a rate increase greater than 150 percent of medical trend for 2 consecutive years; or 4) a rate increase, for discontinued forms, that exceeds the average rate increase approved over the past 6 months for other similar forms of the company currently available for sale, if any, or if none, the average rate increase approved over the past 6 months on forms with similar benefits currently available for sale offered by other companies.

Certain Rate Filing Practices Prohibited

The statutes additionally prohibit the following rating practices by health insurers: 1) select and ultimate premium schedules; 2) premium class definitions which classify insured[s] based on year of issue or duration since issue; and 3) attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over. [s. 627.410(6)(d), F.S.] In general, these types of prohibited rating practices have relatively low premiums when the policy is initially issued, but plan for relatively significant rate increases over the life of the policy as it is renewed.

Prior to discontinuing the availability of a policy form, the insurer must provide 30-days notice to the department and the insurer is prohibited from filing a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department. However, the department may lower the 5-year prohibition if it determines that a shorter period is appropriate. Also, the claims experience of all policy forms providing similar benefits must be combined for all rating purposes. [s. 627.410(6)(d)-(e), F.S.] These requirements are aimed at prohibiting so-called "death spiral" rating practices. This practice is the situation where an insurer stops selling a policy form and bases rates solely on the experience of the individuals covered under the form. As the rates for the group increase, healthy individuals would be permitted to buy a new, similar policy form issued by the insurer, but unhealthy individuals would be denied new coverage, and the rates under the old policy would eventually become unaffordable. The department's proposed

amendments to its current rating rules include a definition of "similar benefits" which would apply to these statutory requirements.

Annual Rate Filing Required

The current law requires that each health insurer make an annual rate filing demonstrating the reasonableness of its premium rates in relation to its benefits. [s. 627.410(7), F.S.] One of the purposes served by this law is to prevent an insurer from waiting multiple years to make a significant rate increase and to instead require smaller, annual rate increases.

Insurers may use a "Loss Ratio Guarantee"

An insurer that issues individual health insurance policies, including Medicare supplement policies, with certain exceptions, is permitted to use a *loss ratio guarantee* as an alternative method of meeting rate filing and approval requirements. [s. 627.410(8), F.S.] Under this procedure, the insurer guarantees that its policies will meet certain minimum loss ratios (see discussion above) and must obtain approval from the department for its initial rates and the durational and lifetime loss ratios. A subsequent filing for an increase in the rates is deemed approved upon filing if it is accompanied by a guarantee that policyholders will be given a refund of the amount necessary to meet the minimum loss ratio if it is not met. The statute specifies particular requirements for calculating and demonstrating whether minimum loss ratio guarantees are met, including an independent audit by the insurer, and authority for the department to establish by rule the minimum information reasonably necessary to be included in the report.

Small Group Policies

Policies issued to small employers with 1 to 50 employees are additionally subject to the *modified community rating* requirements of s. 627.6699, F.S., (not addressed by this bill). This law prohibits insurers from basing rates for small employers on health status or claims experience, and limits variations or differences in rates charged to small employers to five factors: age, gender, geographic location, family size, and tobacco usage.

Exemption for Out-of-State Group Policies

Insurers that issue policies to groups or associations outside of Florida, but which may be sold and marketed to individuals in Florida, are generally exempt from all the rate filing and approval requirements summarized above, except the small group requirements summarized in the above paragraph. (see s. 627.6515, F.S.) The department has identified only 4 insurers as currently issuing individual major medical health insurance policies in Florida. An additional 11 HMOs are identified as issuing individual HMO contracts in the state within their respective geographical service areas. Another 27 insurers have been identified as issuing individual certificates in Florida under out-of-state group policies, which are exempt from the rate filing requirements. However, some of the insurers that are currently marketing coverage in Florida only through individual certificates under out-of-state group policies, also have renewal business for individual policies previously issued in the state, to which Florida's rate riling requirements apply. (See the interim project report by the Banking and Insurance Committee, *Rating Practices of Insurers Issuing Health Insurance Policies and Certificates to Individuals who are Eligible for Guaranteed-Issuance of Coverage*, Report No. 98-05, October 1998).

III. Effect of Proposed Changes:

Committee Substitute for Senate Bill 1556 makes various changes to the laws that apply to health insurance rates. In general, these changes allow for certain rating practices that are currently prohibited; specify certain rate standards and requirements in place of broader department discretion to disapprove a rate filing; provides greater freedom to an insurer to establish separate, segregated groups of policy forms for which claims experience and rates would be based, rather than being required to merge the experience of all similar policy forms; and would revise the requirements for insurers that elect to use a loss-ratio guaranty as a method for a rate filing to be deemed approved.

Certain Large Group Rate Filings Exempt -- The bill amends s. 627.410(1), F.S., to exempt from the rate filing requirements group health insurance policies if the policy forms to which the rate applies are of "unique character which are designed for and used with relation to insurance upon a particular subject or to benefits under group health insurance policies insuring 51 or more persons and are used at the request of the individual policyholder, contract holder, or certificate holder." This provision would appear to exempt from rate filing requirements what are commonly referred to as "single case" filings, where the premiums and benefits are negotiated between the insurer and the employer, in this case an employer with 51 or more employees. However, the distinction between a policy form that has a "unique character" and a policy form that is similar to a standard policy form may not be clear.

Allowance for Segregated Rating Pools -- The bill amends s. 627.410(6)(e) (on pages 3-4) to delete the provisions of current law that prohibit an insurer from filing a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department that it is discontinuing the availability of a policy form, subject to the department lowering the 5-year prohibition if it determines that a shorter period is appropriate. The bill also revises the current requirement that the claims experience of all policy forms providing similar benefits must be combined for all rating purposes. As revised, the insurer would, instead, be required to combine the experience of an individual health insurance policy form *that is no longer being marketed* in Florida with the experience of *at least one other* individual policy form, *providing similar benefits, as determined by the insurer*, which is still being marketed in the state.

These changes provide greater freedom to an insurer to have separate, segregated rating pools for its policies. That is, the claims experience and the rates based on such experience would be segregated into groups with a smaller number of insured lives within each group. This will allow for a much greater variation in the rates charged by the insurer among its various policy forms, likely to result in lower rates for new policy forms and higher rates for policy forms that are no longer being marketed. (See the discussion in Present Situation above as to the "death spiral" rating practices that the current law is intended to prevent.)

Standards for Disapproval of Rate Filings -- The bill amends s. 627.411, F.S., (on pages 11-14), to delete the current grounds for disapproval of a health insurance policy form or rate filing that "contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." The bill retains the requirement that benefits must be reasonable in relation to the

premium charged, but deletes the authority of the department to make this determination based on certain specified factors. Instead, the bill specifies loss ratio requirements that must be met, which are similar to the minimum loss ratio requirements that are established in the current rules adopted by the department. (See Present Situation, above, for a summary of the rule's loss ratio requirements and proposed rule changes.)

In conjunction with the above changes, the bill also amends s. 627.410(7), F.S. (on pages 4-6), relating to the current requirement that health insurers make an annual rate filing. The bill strikes the provisions of the current law which make specific reference to rate filings being "in accordance with the applicable rating laws and rules promulgated by the department." The bill provides that the rate filing requirements of this subsection may be satisfied by documentation demonstrating the reasonableness of the benefits in relation to premiums charged, which would be satisfied if the loss ratio requirements of s. 627.411, F.S., are met and if the insurer meets other specified loss ratio requirements of this section.

The loss ratio standards in s. 627.410(7), F.S., (on pages 5-6) are taken from a 1983 publication of the National Association of Insurance Commissioners (NAIC), *Guidelines for Filing of Rates for Individual Health Insurance*. According to the department, one of the substantive differences between the loss ratio standards of the bill, as compared to the current rule, is that the current rule would not allow an insurer to increase rates solely to make-up for experiencing a higher loss ratio in the previous year than the policy was required to have. That is, each year must stand on its own under the current rules and the insurer is required to meet the minimum loss ratio for each year independently and also meet the minimum loss ratio requirements for the life of the policy. If the insurer has a "bad year" and pays out more in benefits than it was required to provide under the minimum loss ratio requirement for that year, the insurer cannot raise rates the following year solely to gain back the profit that it was permitted to make the previous year. However, the bill would allow this, according to the department.

The bill provides (on page 6) that "interest" (apparently referring to investment income) must be used in the calculation of benefits and premiums "only if it is a significant factor, as determined by the *insurer*." This would change the current rule's requirement that investment income on reserves and unearned premium be considered in calculating benefit and premium requirements, without exception. The bill also provides that anticipated loss ratios lower than those indicated require justification based on applicable special circumstances. The bill lists specific examples of coverages and other factors that may require special consideration. It is not clear to what extent these determinations may be made by the insurer or must be made by the department.

Loss Ratio Guarantee Provisions -- The bill amends the loss ratio guarantee provisions of s. 627.410(8)(c), F.S. (on pages 10-11) Under this procedure (pursuant to both the current law and the bill) the insurer guarantees that its policies will meet certain required minimum loss ratios and must obtain approval from the department for its initial rates and the durational and lifetime loss ratios. A subsequent filing for an increase in the rates is deemed approved upon filing if it is accompanied by a guarantee that policyholders will be given a refund of the amount necessary to meet the minimum loss ratio if it is not met. The changes made by the bill apply to the situation where an insurer has less than 500 policyholders in the state. Currently, the law requires that the insurer use its nationwide loss ratio in this event. Under the bill, if the insurer has less than 2,000 policyholder years nationwide, the experience must be accumulated until the end of the calendar

year in which 2,000 policyholder years are obtained. This has the effect of delaying or denying any refund to policyholders in Florida in the event that the insurer has less than 500 policyholders in the state and less than 2,000 policyholder years nationwide for a particular policy form. If the insurer fails to meet the minimum loss ratio guarantee, the insurer would not be required to provide any refund until the insurer accumulated 2,000 policyholder years nationwide, which may be many years or never.

The bill also provides that the department may not disapprove or withdraw any previous approval of any individual health insurance policy form if rates have been filed as provided under the guaranteed loss ratio provisions of this subsection.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill essentially provides for greater freedom for health insurers to establish and change rates for policies issued in Florida. This is likely to result in a greater degree of rate increases, particularly for persons who have health conditions that make them ineligible for a new policy if their current policy becomes unaffordable. However, it may encourage more insurers to sell insurance in the state and may result in lower rates, at least initially, for persons who do not experience serious health problems. (Other impacts of the bill's changes are more particularly described in Effects of Proposed Changes above).

C. Government Sector Impact:

None or minimal. By eliminating certain discretionary powers of the department, there may be fewer administrative challenges to rate filings made by insurers.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.