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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1753

RELATING TO: Health Insurance

SPONSOR(S): Rep. Patterson

COMPANION BILL(S): SB 1576 (s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 15 NAYS 0
(2) INSURANCE
(3) GOVERNMENTAL RULES AND REGULATIONS
(4)
(5)

I. SUMMARY:

HB 1753 removes the Department of Insurance's authority to promulgate rules setting standards for rate filing and approval, and sets out in statute, rather than administrative rule, standards to determine the reasonableness of rates.

The bill requires the department to disapprove or withdraw any previous approval of any individual accident and health insurance policy form if certain standards are met which establish that premium rates are not excessive or inadequate. Loss ratio standards to be satisfied for proof that premium rates are not excessive are set out in the bill. In addition, exceptions to these standards are established in the bill as follows:

- Group conversion insurance, other long-term-care insurance, and Medicare supplement insurance, issued on either a group or individual basis, shall have a loss ratio of not less than 120 percent, subject to the limits described in s. 627.6675, F.S.
- The minimum loss ratio for blanket insurance shall be 65 percent.
- The minimum loss ratios for Medicare supplement insurance shall be established in accordance with s. 627.674, F.S., and the minimum loss ratios for long-term care insurance will be established in accordance with s. 627.9407, F.S.

In addition, the bill provides that premium rates qualify as not inadequate if the insurer demonstrates, in accordance with generally accepted standards of actuarial practice, that the sum of premium income and investment income, minus the sum of benefit payments, expenses, taxes, and contingency margins is greater than zero.

The bill removes the prohibition of the use of durational rating in certain circumstances, and permits carriers to discontinue sales of a policy form and issue a new one with similar benefits without waiting a period of 5 years to file for approval.

The bill also removes the requirement that the experience of all policy forms providing similar benefits shall be combined for all rating purposes. In place of this requirement, the bill requires the experience of an individual accident and health insurance policy form that is no longer being marketed in this state, except for policies rated pursuant to a loss ratio guarantee set in statute, to be combined with the experience of at least one other individual accident and health insurance policy form providing similar benefits, as determined by the insurer, which is still being marketed in the state by the same insurer, unless the insurer has no current policy form with similar benefits still being marketed in the state.

According to the Department of Insurance, this bill should have no fiscal impact on state and local government.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

The provisions of ch. 627, F.S., relate to insurance rates and contracts as part of the Florida Insurance Code. Part II of ch. 627, F.S., consisting of ss. 627.401-627.4301, F.S., relates to insurance contracts.

Section 627.410, F.S., 1998 Supplement, provides that "no basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the Department of Insurance at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department. This section further establishes requirements to be met by insurers for annual rate filing and rate change proposals. In addition, the department has the authority to establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates.

Section 627.411, F.S., provides the circumstances for which the department may disapprove or withdraw approval of forms filed under s. 627.410, F.S. This section also includes factors to be considered when the department is determining whether the benefits are reasonable in relation to premiums charged.

Rule 4-149.005, F.A.C., sets requirements for determining the reasonableness of benefits in relation to premiums. This administrative rule states that "benefits will be determined to be reasonable in relation to the premium rates charged if the premium schedule is not excessive, not inadequate and not unfairly discriminatory. In determining whether a premium schedule satisfies these requirements, the Department will consider all items presented in the filing with special emphasis placed on the information included in the actuarial memorandum."

In addition, Rule 4-149.005, F.A.C., establishes the following loss ratio standards.

Loss Ratio Table, Group Policies

Group Medical Expense:

Group Size	Loss Ratio
Fewer than 51 certificates	65 percent
51 through 500 certificates	70 percent
All others	75 percent

Group Medical Indemnity or Any Group Policy with an Average Annual Premium per Certificate of Less Than $1,000:

Group Size	Loss Ratio
Fewer than 51 certificates	57.5 percent
51 through 500 certificates	62.5 percent
All others	67.5 percent

Loss Ratio Table, Individual Policies for the Line of Business Indicated

Medical Expenses:

Renewal Clause	Loss Ratio
Noncancelable	55 percent
Nonrenewable	60 percent
Guaranteed Renewable	65 percent

All others	70 percent
Minimum Acceptable	55 percent

Medical Indemnity, Loss of Income:

Renewal Clause	Loss Ratio
Noncancelable	50 percent
Nonrenewable	55 percent
Guaranteed Renewable	60 percent
All others	65 percent
Minimum Acceptable	50 percent

According to the rule, blanket insurance is exempt from the loss ratios required above, and the minimum loss ratio for blanket insurance is 65 percent. The rule also establishes that "group conversion insurance, other than long-term care and Medicare supplement insurance, issued on either a group or an individual basis, is exempt from the loss ratios required above. The loss ratio for group conversion insurance shall not be less than 120 percent. The insurer may charge the excess of the group conversion loss ratio over that required for group insurance on active lives to the experience for insurance on active lives. The premium to be charged for group conversion insurance may not exceed the limits of s. 627.6675, F.S."

B. EFFECT OF PROPOSED CHANGES:

The Department of Insurance's authority to promulgate rules setting standards for rate filing and approval will be removed, and standards to determine the reasonableness of rates will be set in statute rather than administrative rule.

The department will be required to disapprove or withdraw any previous approval of any individual accident and health insurance policy form if certain standards are met which establish that premium rates are not excessive or inadequate. Loss ratio standards to be satisfied for proof that premium rates are not excessive will be set in statute. In addition, exceptions to these standards will be established as follows:

- Group conversion insurance, other long-term care insurance, and Medicare supplement insurance, issued on either a group or individual basis, will have a loss ratio of not less than 120 percent, subject to the limits described in s. 627.6675, F.S.
- The minimum loss ratio for blanket insurance will be 65 percent.
- The minimum loss ratios for Medicare supplement insurance will be established in accordance with s. 627.674, F.S., and the minimum loss ratios for long-term care insurance will be established in accordance with s. 627.9407, F.S.

Premium rates will qualify as not inadequate if the insurer demonstrates, in accordance with generally accepted standards of actuarial practice, that the sum of premium income and investment income, minus the sum of benefit payments, expenses, taxes, and contingency margins is greater than zero.

The prohibition of the use of durational rating in certain circumstances will be removed, and durational rating will be permitted to be used as a rating tool.

Carriers will be permitted to discontinue sales of a policy form and issue a new one with similar benefits without waiting a period of 5 years to file for approval.

The requirement that the experience of all policy forms providing similar benefits shall be combined for all rating purposes will be removed and replaced with language that requires the experience of an individual accident and health insurance policy form that is no longer being marketed in this state, except for policies rated pursuant to a loss ratio guarantee set in statute, will be combined with the experience of at least one other individual accident and health insurance policy form providing similar benefits, as determined by the insurer, which is still being marketed in the state by the same insurer, unless the insurer has no current policy form.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. The Department of Insurance's authority to approve or disapprove or withdraw approval for health insurance policy forms and rates will be significantly reduced.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      No.

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      No.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      Insurance carriers will have increased control in their ability to set policy rates and will be given discretion as to how to comply with rate requirements in certain situations.

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      No.

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

      N/A

      (2) Who makes the decisions?

      N/A

      (3) Are private alternatives permitted?

      N/A

      (4) Are families required to participate in a program?

      N/A

      (5) Are families penalized for not participating in a program?

      N/A

   b. Does the bill directly affect the legal rights and obligations between family members?

      No.

   c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 627.410 and 627.411, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends section 627.410, F.S., relating to filing and approval of insurance contract forms. The following subsections are amended:

Subsection (6) is amended to remove the prohibition against premium class definitions which classify insured based on year of issue or duration since issue for rating practice purposes.

Provisions are removed that: require an insurer to continue to make available for purchase any individual policy form issued on or after October 1, 1993; provide that a policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months; and require an insurer that discontinues the availability of a policy form to wait 5 years after the insurer provides notice to the department of the discontinuance to file for approval a new policy form providing similar benefits as the discontinued form.

The requirement that the experience of all policy forms providing similar benefits shall be combined for all rating purposes is removed and replaced with language that requires the experience of an individual accident and health insurance policy form that is no longer being marketed in this state, except for policies rated pursuant to a loss ratio guarantee under subsection (8) to be combined with the experience of at least one other individual accident and health insurance policy form providing similar benefits, as determined by the insurer, which is still being marketed in the state by the same insurer, unless the insurer has no current policy form.

Subsection (7) is amended to require insurers to *establish*, rather than *demonstrate,* the reasonableness of benefits in relation to premium rates. The requirement that rate filings comply with laws and rules promulgated by the department is removed, and rate filing requirements are established providing that for premium rate changes, benefits shall be deemed reasonable in relation to premium charged if both of the following loss ratios meet or exceed the standards established in s. 627.411(2), F.S. Lifetime loss ratios must exceed the loss ratio standard for the form and the future loss ratio must exceed the loss ratio for the form. If interest is a significant factor, as determined by the insurer, it shall be used in the calculation of the accumulated benefits and premiums and present values. Factors are specified which may be used in determining: the present value of benefits; the present value of premiums; coverage special considerations; and other factor special considerations.

The requirement that, if no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the department is removed, and to require such filing to be in accordance with the loss ratio established in this section and s. 627.411(2), F.S.

Subsection (8) is amended to: permit Medicare Supplement policies to be filed pursuant to loss ratio guarantee; remove the Department of Insurance's authority to disapprove or withdraw approval of a form if filed under a loss ratio guarantee; and establish that compliance requirements for such forms are set in this section. For calculations of an "applicable loss ratio," authority is granted that, if there are 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. Establishes that the department

shall not disapprove or withdraw any previous approval of any individual accident and health insurance form pursuant to s. 627.411(1)(e), F.S., if rates have been filed as provided in this subsection.

Section 2. Amends s. 627.411, F.S., relating to disapproval of forms, to remove the authority of the Department of Insurance to disapprove or withdraw any previous approval, if the form contains provisions which are unfair or inequitable or contrary to the public policy of this state 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. Removes the department's authority to determine whether benefits are reasonable in relation to the premium charged through the use of reasonable actuarial techniques, and provides that benefits are deemed reasonable in relation to the premium charged if premium rates are neither excessive no inadequate.

Loss ratio standards for determining whether premiums are deemed to be not excessive are as follows:

Loss Ratio Table, Individual Policies for the Line of Business Indicated

Medical Expenses:

Renewal Clause	Loss Ratio
Noncancelable	55 percent
Nonrenewable	60 percent
Guaranteed Renewable	65 percent
All others	70 percent

Medical Indemnity, Loss of Income:

Renewal Clause	Loss Ratio
Noncancelable	50 percent
Nonrenewable	55 percent
Guaranteed Renewable	60 percent
All others	65 percent

Loss Ratio Table, Group Policies

Group Medical Expense:

Group Size	Loss Ratio
Fewer than 51 certificates	65 percent
51 through 500 certificates	70 percent
All others	75 percent

Group Medical Indemnity or Any Group Policy with an Average Annual Premium per Certificate of Less Than $1,000:

Group Size	Loss Ratio
Fewer than 51 certificates	57.5 percent
51 through 500 certificates	62.5 percent
All others	67.5 percent

Exceptions to these standards include the following:

Group conversion insurance, other long-term care insurance and Medicare supplement insurance, issued on either a group or individual basis, shall have a loss ratio of not less than 120 percent, subject to the limits described in s. 627.6675, F.S.

Blanket insurance is exempt from the loss ratios described above, and the minimum loss ratio for blanket insurance is 65 percent.

Medicare supplement and long-term care insurance are exempt from the loss ratios described above. The minimum loss ratios for Medicare supplement insurance shall be established in accordance with s. 627.674, F.S. The minimum loss ratios for long-term care insurance shall be established in accordance with s. 627.9407, F.S.

Premium rates are not inadequate if the insurer demonstrates, in accordance with generally accepted standards of actuarial practice, that the sum of premium income and investment income, minus the sum of benefit payments, expenses, taxes, and contingency margins is greater than zero.

Section 3. Provides for an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Unknown.

2. Direct Private Sector Benefits:

Unknown.

3. Effects on Competition, Private Enterprise and Employment Markets:

Unknown.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring expenditures of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the ability of counties and municipalities to raise revenue.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill does not reduce state tax shared with counties and municipalities.

V. COMMENTS:

It appears that the loss ratio standards that are incorporated into statutes by this bill mirror those standards in current Department of Insurance rules. It is unclear why such detail needs to be in statute.

According to the Department of Insurance, this legislation generally removes the department's ability to protect consumers from health insurance rates and forms for which the rate is not reasonable in relation to the benefits provided. In addition, the department has the following concerns:

- The removal of the prohibition against durational and generational rating will permit premiums to increase for each year the policy is in force, and these policy increases, when combined with annual increases for medical trend, experience, and increasing age of the insured, result in material increases each renewal anniversary. Generational rating allows forms to be rated on a year of issue basis. Two insureds with the same expectation of claim will have different premiums based solely on the year they purchased coverage.

- The removal of the prohibition of five years before a form may be approved if a form with similar benefits is discontinued will allow a company to close a form when claims increase and start a new one at lower rates.

- On page 3, lines 12 and 13, "accident" and "health" are not defined.

- The bill provides that if the carrier is currently issuing similar coverage, a closed form must be pooled with one form currently issued. The choice of which form to pool is at the company's option. If there is no current form, there is no requirement to pool all closed forms.

- The bill provides that the lifetime loss ratio must exceed the loss ratio standard for the form and the future loss ratio must exceed the loss ratio standard for the form. This does not reflect that prefunded policies, such as Medicare supplement, long-term care, and individual major medical, start out with low loss ratios that increase each year with ultimate loss ratios sometimes exceeding 100 percent. The bill does not recognize this inherent increase in loss ratio pattern of some products. The proposed standard does not recognize that the expected claims for certain policies is expected to start off low and increase each year as a normal result of the coverage. The bill does not recognize that profits are expected to occur in early years with losses paid in later years. The bill permits a company to charge higher rates in the future to recapture past losses paid. This permits the insurer to increase rates to future policyholders in order to get repaid for claims in the past.

- By permitting the determination of present values with an interest rate to be at the option of the insurer, the time value of money is not recognized.

- The bill permits active life reserves to be used in determining loss ratio compliance, but does not establish any standard for the active life reserve.

- The bill removes the ability to disapprove or withdraw approval of a form if filed under a loss ratio guarantee. If a form does not add mandated benefits as adopted by law over the years, the department would not have the ability to withdraw approval of the form even though it is in violation of the statute.

- The bill removes the ability to withdraw approval of a previously approved form if the form is issued under a loss ratio guarantee, but there is no disclosure to the consumer that the form is subject to a loss ratio guarantee.

- By permitting the insurer to not issue refunds for a given calendar year if there are less than 2000 policyholders nationwide, life years will be accrued until 2000 life years is reached and then a refund is determined by the accumulated experience over those years. The refund is given to those in force at the end of the period. If the department took three years to accumulate experience, and loss ratios are good, anyone who terminated coverage will not be eligible for a refund.

- The bill states that the loss ratio values which are the standards for the forms, but the levels are not adjusted to include active life reserves as proposed.

- On page 12, line 27, the reference to the Medicare supplement statute should be s. 627.6745, F.S., instead of s. 627.674, F.S.

- The bill establishes a standard that rates not be inadequate but does not address if this is for new forms only or if it also applies at the time of a rate increase filing. If a company paid an unexpected catastrophic claim in a prior year, a rate adjustment making future premiums unrealistic could mathematically be required to meet this standard. Such a standard should only apply at the time of new form approval.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 12, 1999, the Committee on Health Care Services passed the following amendments:

Amendment #1 (offered by Rep. Goode): On page 1, lines 15-26: This amendment:

- Provides that certain requirements for filing forms with the Department of Insurance do not apply to "specially rated inland marine risks."

- Limits a reference to health insurance to "individual or small group" health insurance.

- Provides that the provision of s. 627.410(6)(a), F.S., does not apply to rating manuals, rating schedules, changes in rating manuals or schedules, or if rating manuals or schedules are not applicable, to premium rates or changes in such rates, relating to policies, riders, endorsements, or

forms 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.

Amendment #2 (offered by Rep. Goode): On page 2, lines 18-19: This amendment reinstates deleted language relating to the prohibition against durational and generational rating.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams