STORAGE NAME: h0397s1.hcs
DATE: February 24, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: CS/HB 397

RELATING TO: Health Insurance

SPONSOR(S): Committee on Health Care Services and Representative Patterson

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 11 NAYS 4
(2) INSURANCE
(3)
(4)
(5)

I. SUMMARY:

CS/HB 397 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 statute.

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 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 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. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes [x]	No []	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. 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., provides, in subsection (1), 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."

C. EFFECT OF PROPOSED CHANGES:

The bill would make various changes to the laws that apply to health insurance rates, ss. 627.410 and 627.411, F.S. In general, these changes would: allow insurers to utilize certain rating practices that are currently prohibited; specify certain loss ratio 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 on which claims experience and rates would be based, rather than being required to merge the experience of all similar policy forms.

More specifically:

- The bill would remove the department's authority to disapprove a health insurance policy form or rate filing based on the policy containing "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." The bill would retain the requirement that benefits must be reasonable in relation to the premium charged. The bill would also specify 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.

- The bill would delete 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.

- The bill would delete 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.

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

D. 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 (1) is amended to limit the applicability of form filing and approval under this section to *individual or small group* health insurance, rather than health insurance generally, and to delete reference to the inapplicability of this section to surety bonds.

Subsection (3) is amended to specify that Department of Insurance form and rate approval withdrawal be pursuant to s. 627.411(1), F.S., which is substantially amended by section 2 of the bill, and not "for cause," as current law specifies.

Subsection (6) is amended to specify that this provision 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.

The Department of Insurance is authorized to establish, by rule, for each type of health insurance form, procedures to be used in ascertaining "that a form meets the standards in s. 627.411(2) for new rate filings and rate revisions in accordance with generally accepted standards of actuarial practice," rather than "the reasonableness of benefits in relation to premium rates," the current standard.

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. Language is also added which specifies that, for purposes of this section, a form is considered active if the form has been marketed in this state in the past 6 months, as opposed to the current requirement which specifies a 12 month period.

Subsection (7), relating to form filing requirements, is amended to specify that insurance policy forms, excluding noncancellable policy forms, must establish compliance with the standards of s. 627.411(2), F.S., relating to the Department of Insurance's form approval, as substantially rewritten by section 2 of the bill.

This subsection also requires 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. Interest 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; anticipated loss ratios; 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

language is added to require such filing to be in accordance with the loss ratio established in this section and s. 627.411(2), F.S.

Language is added to specify that, for premium rate changes for group policy forms, benefits shall be reasonable in relation to premium charged if the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage meets or exceeds the standards established in the revised s. 627.411(2), F.S.

Authorization is also added for an insurer to combine the experience of similar policy forms in the required filing.

In those instances in which an insurer fails to meet filing requirements and does not submit the filing within 60 days of the date the filing was due, the Department of Insurance may order the insurer to discontinue issuance of the policies for which the required filing was not made until such time as the required filing is submitted. Language is deleted which relates to the Department of Insurance determining that the required filing is properly submitted under such circumstances.

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.

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, as specified in subsection (2).

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. 627.6745, F.S. The minimum loss ratios for long-term care insurance shall be at least 60 percent, based on specified criteria.

Methodologies are specified for the calculation of the anticipated future loss ratio and the lifetime loss ratio, including the use of interest.

For minimum loss ratios, the dates of June 1, 1994, and February 1, 1994, are made applicable to individual contracts and group certificate forms, providing a “grandfathering” of certain forms.

An insurer is required to justify an anticipated loss ratio lower than those otherwise specified, based on applicable special circumstances.

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, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Unknown.

D. FISCAL COMMENTS:

None.

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 the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

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

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The Department of Insurance's rule-making authority specific to rate form approval for health insurance policies written in this state are greatly curtailed by this bill.

C. OTHER COMMENTS:

General staff comment: 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.

Department of Insurance Concerns: 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 expressed the following specific concerns:

- 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. (page 4, lines 12-18)

- On page 4, lines 19-20, "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. (page 4, lines 19-30)

- 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 pre-funded 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. (page 5, lines 18-31)

- 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. (page 6, lines 14-21)

- 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. (page 6, lines 14-20)

- The period rate filing standards for premium rate changes as established in section 1 of the bill as part of the revisions to s. 627.410(7), F.S., seem to be at odds with similar calculations required for purposes of loss ratio determinations as established in section 2 of the bill as part of revisions to s. 627.411(2), F.S. (page 5, line 16 thru page 6, line 12 compared to page 16, lines 7-25)

- 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. (page 11, lines 13-16)

- The “grandfather” provisions for certain forms approved in 1994 may set up a double standard for form review purposes. (page 16, lines 26-31)

- 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. (page 17, lines 14-18)

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

Five amendments, sponsored by Representative Patterson, were adopted. These amendments: deleted an exemption of long-term care policies from the prohibition against the use of attained age premium structures; clarified the applicability of filing requirements for certain guaranteed renewable policies; clarified the applicability of certain loss ratio thresholds; corrected a cross-reference relating to Medicare supplement policy loss ratios; and restored limited rule-making authority for the Department of Insurance for purposes of rate filing and review. The bill was approved as a committee substitute.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams