SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 1210

SPONSOR: Banking and Insurance Committee and Senator Latvala

SUBJECT: Health Insurance

DATE: March 21, 2001 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.			AGG	
3.			AP	
4.				
5.				
6.				

I. Summary:

The bill makes the following changes to the laws regulating health insurance policies, health maintenance organization (HMO) contracts, Medicare supplement policies, and long-term care policies:

1. If an insurer requires individual underwriting to determine coverage eligibility or premium rates to be charged to a Florida resident covered under a group policy issued outside of Florida, the bill requires that the certificate issued in Florida be subject to the same requirements of the Insurance Code that apply to individual health insurance policies issued in Florida.

2. Group health insurance policies and HMO contracts insuring groups of 51 or more persons would be exempt from rate filing requirements, except for Medicare supplement policies, long-term care policies, and certain other policies.

3. Insurance policy forms with fewer than 1,000 nationwide policyholders or insured members would be exempt from annual rate filing requirements and would be allowed to file for an annual rate increase limited to medical trend.

4. The bill establishes specific actuarial criteria for rate disapproval and deletes the provision that allows for the department to disapprove health insurance rates “which result in premium escalations that are not viable for the policyholder market.”

5. The bill requires carriers writing individual policies to offer “HIPPA-eligible” individuals the standard and basic policy that small group carriers are required to offer, rather than the insurer’s two most popular policy forms. The bill also prohibits individual carriers

from applying discriminatory underwriting and rating practices to HIPAA-eligible individuals.

6. Small group carriers would be allowed to separate the experience of their insured one-life groups (employers with one employee, sole proprietors, and self-employed individuals) into a separate rating pool, apart from the rating pool for their insured groups with 2-50 employees. But, the rate for one-life groups could not exceed 150 percent of the rate for groups of 2-50 employees. The bill also provides that small group carriers may only provide credits (not surcharges) due to duration of coverage (the time period that a small employer has been insured with the carrier).

7. The bill requires that Medicare supplement insurers offer policies on a guaranteed-issue basis to individuals who are under 65 years of age and eligible for Medicare by reason of disability, except for end-stage renal disease beneficiaries.

8. The bill authorizes the department to adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners. The provisions are designed to prevent insurers from implementing large rate increases after a policy has been issued.

This bill substantially amends the following sections of the Florida Statutes: 627.410, 627.411, 627.6487, 627.6515, 627.6699, 627.6741, 627.9408, and 641.31.

II. Present Situation:

Health Insurance Rate and Form Filing Requirements

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 disapprove the rate within 30 days, but may extend this period for an additional 15-days. These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies. Similar requirements are established in s. 641.31(3), F.S., for health maintenance organization (HMO) 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.]

For HMO contracts, the department may disapprove rates that are excessive, inadequate, or unfairly discriminatory, which may be defined by rule of the department, in accordance with generally accepted actuarial practice as applied by HMOs. The department may also disapprove a rate if the rating methodology followed by the HMO is determined by the department to be

inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. [s. 641.31(2), F.S.]

The department has adopted rules that 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. 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 3 years, the department has attempted to revise their health insurance rating rules, which have been the subject of continuing legal challenges. One issue was the 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." A circuit court opinion determined that this standard was too broad and was an unconstitutional delegation of legislative authority.

Certain insurer rating practices are expressly prohibited, designed to prohibit scheduled rate increases solely due to age of the policyholder: 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.

Certain rating laws are designed to prohibit so-called “death spiral” rating practices. This is the practice where an insurer stops selling a policy form and bases rates solely on the experience of the individuals covered under the form. As claims and the rates for the group increase, healthy individuals are able to meet underwriting standards to buy a new policy issued by the same insurer. But, unhealthy individuals are denied new coverage and the rates under the old policy continue to escalate due to the declining pool of insureds and worsening claims experience. Eventually the rates become unaffordable. The practice is then repeated with the new policy form. To prevent such death spiral rating practices, the Florida law requires that the claims experience of all policy forms providing similar benefits be combined (or "pooled") for all rating purposes. An insurer must provide 30 days notice to the department prior to discontinuing the availability of a policy form, and the insurer is prohibited from filing a new policy form providing similar benefits for at least 5 years, subject to a shorter period approved by the department. [s. 627.410(6)(d)-(e), F.S.]

Health insurers must make an annual rate filing demonstrating the reasonableness of its premium rates in relation to benefits. [s. 627.410(7), F.S.] This law prevents an insurer from waiting multiple years to make a significant rate increase and, instead, effectively requires smaller annual rate increases or a certification that no rate increase is necessary.

An insurer that issues individual health insurance policies is permitted to use a loss ratio guarantee as an alternative method for 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 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.

Limited Regulation of Out-of-State Group Policies

Insurers that issue policies to groups or associations outside of Florida, but which are sold and marketed to individuals in Florida (who are issued "certificates"), are generally exempt from Florida's rate filing and approval requirements. The law requires that the group certificates issued in Florida be filed with the department "for information purposes only." [s. 627.410(1), F.S.] The law further provides that if the group is established primarily for the purpose of providing insurance, the benefits must be reasonable in relation to the premiums charged. (s. 627.6515, F.S.) Even though this provision provides the department with some authority to determine whether rates are reasonable, this has not proven to be effective due to: 1) the lack of any rate filing requirement, 2) the fact that specific rating laws, such as those designed to prohibit "death spiral" rating practices, do not apply to out-of-state group policies, and 3) the difficulty of proving that a group has been formed primarily for insurance purposes when the group has established other paper credentials as to some other purpose.

The department reports that it has received many complaints from Florida residents covered under out-of-state group policies relative to the "death spiral" rating practices that are prohibited under policies issued in Florida. The department has identified 10 insurance companies and 10 HMOs that issue individual policies in Florida, as compared to 17 insurance companies that market individual coverage in Florida through out-of-state associations.

However, the requirements of the laws that apply to policies issued to small employers, summarized below, apply to out-of-state associations covering a small employer in Florida. Also, Florida laws for Medicare supplement policies apply Florida's rating laws to certificates covering Florida residents under an out-of-state group policy. (ss. 627.672 and 627.6745, F.S.) Similarly, for long-term care policies, the current law provides that coverage may not be issued in Florida under a group policy issued to an association in another state, unless Florida or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Florida, has made a determination that such requirements have been met. Evidence to this effect must be filed by the insurer subject to the procedures specified in s. 627.410, F.S.

Prior to solicitation in Florida of out-of-state group coverage, a copy of the master policy and a copy of the form of the certificate that will be issued to Florida residents must be filed with the department for informational purposes. The certificates must contain the following statement: "The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida." Out-of-state group policies are subject to some, but not all, of the statutorily mandated benefits, as specified in s. 627.6515(2)(c), F.S., but the level of enforcement of such requirements is much less than for in-state policies due to the absence of any requirement for filing policy forms with the department for approval.

Florida law currently treats out-of-state group insurers the same as an insurer issuing individual policies in one important respect. Florida's HIPAA-conforming legislation requires individual health insurance carriers to guarantee-issue coverage to HIPAA-eligible individuals who are not eligible for a conversion policy. This requirement applies to carriers issuing certificates to Florida residents under a group policy issued to an association outside of Florida, as well as carriers issuing individual policies in Florida. [s. 627.6487(2)(b), F.S.]

Small Employer Policies

The Employee Health Care Access Act in s. 627.6699, F.S., requires insurers in the small group market to guarantee the issue of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition.

Legislation in 2000 provided that employers with fewer than 2 employees, typically referred to as "one-life groups," are now limited to a one-month open enrolment period in August of each year, rather than the year-round guarantee-issue requirement that previously applied, and that continues to apply to employers with 2-50 employees. [ch. 2000-256 and 2000-296, L.O.F.] The 2000 law also changed the requirements for "modified community rating," which previously prohibited insurers from considering health status or claims experience in establishing premiums, and allowed only age, gender, geographic location, tobacco usage, and family size to be used as rating factors. As amended, the law now allows small group carriers to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these factors.

Carriers have consistently reported that their claims experience for one-life groups is much worse than for larger size employers. The department notes, as an example, that some carriers report a loss ratio of about 135 percent for one-life groups, meaning that for every one dollar of premium, the insurer pays $1.35 in benefits.

Guaranteed Availability of Individual Coverage under HIPAA

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and meet other eligibility criteria. HIPAA allowed each state the option to enact and enforce the federal provisions or fall back to federal enforcement. The act also allowed each state to craft alternative methods of guaranteeing availability of coverage.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA). To be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a group plan, a governmental plan, or church plan. However, in 1998, Florida expanded the eligibility criteria under state law to also include

persons whose most recent coverage was under an individual plan if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. Legislation in 2000 limited this provision to prior individual coverage issued in Florida.

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. These mechanisms apply after exhaustion of the period of time that group coverage can be continued under the federal COBRA law or Florida's "mini-COBRA" law, which, generally, is up to 18 months. One method requires the insurance company or HMO that issued the group health plan to offer an *individual conversion policy* to persons who lose their eligibility for group coverage. At least two conversion policy options must be offered, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. Florida's second method of guaranteeing access to individual coverage is allowing eligible individuals to purchase an *individual policy from any insurance company or HMO issuing individual coverage in the state*. The policy must be offered on a guaranteed-issue basis, regardless of the health condition of the individual. The insurer or HMO must offer each of their *two most popular policy forms*, based on statewide premium volume. This method applies to eligible persons who are not entitled to a conversion policy under ss. 627.6675 or 641.3921, F.S. This generally includes persons who were previously covered under a self-insured employer's plan or who move out of the service area of an HMO.

According to the department, the requirement for individual health insurance carriers to offer their two most popular policy forms to HIPAA-eligible individuals has resulted in carriers reducing the benefits available under their most popular policies. For example, maternity coverage is commonly excluded from carriers' two most popular policy forms.

The department interprets the current law as prohibiting an individual carrier from discriminating against HIPAA-eligible individuals in the premium rates charged. Under this interpretation, a carrier is permitted to surcharge a HIPAA-eligible individual based on health status, as long as the carrier imposes the same surcharge on non-HIPAA-eligible persons applying for coverage.

Medicare Supplement Insurance

A "Medicare supplement policy" is defined under part VIII of chapter 627 (ss. 627.671 - 627.675, F.S.), as a health insurance policy or health benefit plan, offered by a private entity to individuals entitled to Medicare benefits. The supplemental policy provides reimbursement for medical expenses incurred, which are not reimbursable by Medicare because of applicable deductibles, coinsurance amounts or other limitations imposed by Medicare.

Insurers issuing Medicare supplement insurance must offer such policies on a guaranteed-issue basis, without regard to health status and without discrimination in the price, to any individual during the first 6 months after he or she reaches age 65 and enrolled in Medicare part B. Persons over age 65 are also entitled to guaranteed-issue of a Medicare supplement policy during the 2-month period following termination of coverage under a group health insurance policy.

However, Florida law does not afford the same right to guaranteed-issue of a Medicare supplement policy to persons under age 65 who become entitled to Medicare due to total

disability. According to information obtained from the Department of Insurance, 19 states have such laws.

Long Term Care Insurance

Florida's Long-Term Care Insurance Act (ss. 627.9401-627.9406, F.S.) establishes minimum requirements for the content and sale of long-term care insurance. Long-term care is generally considered to be assistance with daily living activities for individuals who, because of a physical or mental disability, are unable to function independently. Long-term care ranges from non-medical support services provided in a person's home to intensive medical services and continuous monitoring provided in a skilled nursing facility. As defined in the Act, "long-term care insurance" means any insurance policy that provides coverage for "one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital" subject to specified exceptions, (s. 627.9404, F.S.).

The Act requires a long-term care policy to provide coverage for at least 2 years for care in a nursing home, and for at least 1 year for a lower level of care, as defined by department rule, such as home health care or adult day care. The Act also prohibits certain policy exclusions and limitations, such as prohibiting more than a 180-day elimination period, which is the number of days that a policyholder must pay for care before the policy begins paying benefits, (s. 627.9407(3), F.S.). Certain benefits must be offered as an option, such as inflation protection and non-forfeiture benefits, (s. 627.94072, F.S.). A non-forfeiture benefit is a paid-up benefit to a policyholder if the policy is canceled. The insurer must offer a non-forfeiture benefit in one of three forms: (1) a cash refund, (2) a shortened benefit period, or (3) a smaller dollar indemnity amount. The law provides a minimum standard for the calculation of a shortened benefit period only. The standard shortened benefit period credit must equal 100 percent of all premiums paid and not less than 30 times the daily nursing home benefit. Any other type of non-forfeiture benefit, such as a cash refund, must provide a benefit that is actuarially equivalent to the method specified for a shortened benefit period.

The department is required to adopt rules establishing loss ratio and reserve standards for long-term care insurance, established at levels at which benefits are reasonable in relation to premiums and that provide for adequate reserving of the long-term care insurance risk. As for other types of health insurance, a long-term care insurance policy may not have a rate structure under which the premiums are calculated to increase based solely on the age of the insured. [s. 627.9407(6)-(7), F.S.]

The National Association of Insurance Commissioners has adopted Long-Term Care Insurance Model Regulations (2000). One area, not specifically addressed in the Florida law, is more effective protections against premium increases. Although Florida law authorizes the department to establish minimum loss ratios and requires insurers to seek approval for rate increases, policyholders may still experience rate increases, due to worsening claims experience of the insurer, many years after they obtained a long-term care policy with the expectation that premiums would remain relatively stable. The NAIC Model Regulations (“Model”) address this issue by allowing greater freedom to insurers to establish the initial rate and providing stronger regulatory authority to disapprove rate increases. More specifically, the model deletes the loss

ratio test as an initial standard of approval, requiring only a review of the actuarial certification supporting the rates, while still allowing for disapproval of rates that are inadequate. The Model also requires a stronger actuarial certification than currently required under Florida law, requiring the actuary to certify that the rates are sustainable, under moderately adverse experience, over the life of the form with no rate increase expected. The initial premium level would be subject to a 58 percent loss ratio, but rate increases would be subject to an 85 percent loss ratio. The Model requires insurers to disclose to consumers, at the time of sale of a long-term care policy, any rate increase on any of its long-term care policy forms for the past 10 years.

As further protection against large rate increases, the NAIC Model Regulations require insurers to provide a "contingent benefit upon lapse." This is in addition to the non-forfeiture benefit that Florida law currently requires long-term care insurers to *offer*, which provides a paid-up benefit if the policy is canceled after a certain time period. Under the Model, the contingent benefit upon lapse would be provided under *all* policies, even if the non-forfeiture benefit were rejected. It would apply a paid-up benefit equal to the sum of all premiums paid if a rate increase of a certain percentage is followed by a lapse of the policy due to non-payment of premium. The percentage rate increase that triggers the benefit depends on the age of the policyholder when the policy was issued. For example, a 200 percent rate increase would trigger the benefit for a person who was age 29 when the policy was purchased, a 110 percent rate increase would trigger the benefit for a person who was age 50, 70 percent for a person who was age 60, 40 percent for age 70, 20 percent for age 80, and 10 percent for 90 and over. Under certain conditions, the department would be authorized to require certain administrative and underwriting changes, to require the insurer to offer alternate policies to the insured without underwriting, withdraw approval of all forms, or have the insurer exit the long-term care business.

III. Effect of Proposed Changes:

Section 1 amends s. 627.410, F.S., Filing, approval of forms. Subsection (1) is amended to provide an exception to the current provision that group certificates need only be filed with the department for informational purposes if a group policy is issued outside of Florida but covers Florida residents. The bill provides that if the insurer requires individual underwriting to determine coverage eligibility or premium rates to be charged, the group certificate issued in Florida would be subject to the same requirements of the Insurance Code that apply to individual health insurance policies issued in Florida. (The bill makes conforming changes to s. 627.6515, F.S., below.) This would require that group certificates issued in Florida comply with all mandatory benefits and rate filing laws that currently apply to individual health insurance policies if the insurer requires individual underwriting to determine eligibility or premiums.

Subsection (6) is amended to exempt from rate filing requirements group health insurance policies insuring groups of 51 or more persons, except for Medicare supplement policies, long-term care policies, and any coverage where the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

Subsection (7) is amended to provide an exception to the annual rate filing and actuarial memorandum requirement if an insurer has fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms. Such insurers would be permitted to file for an annual rate increase limited to medical trend as adopted by the

department pursuant to s. 627.411(4), as amended by the bill (below). These provisions would not apply to Medicare supplement insurance.

Section 2 amends s. 627.411, Grounds for disapproval. The bill deletes the provision that allows for the department to disapprove health insurance rates "which result in premium escalations that are not viable for the policyholder market." In place of this provision, the bill establishes specific criteria for rate disapproval. In all cases a rate increase must be actuarially justified, but even if it is, the department would be required to disapprove the rate increase in certain situations that are due to actions of the insurer, as follows:

1. The department would disapprove the rate increase if it is due to the insurer reducing the portion of the premium used to pay claims from the loss-ratio standard certified in the insurer's last actuarial certification, and the increase is in excess of the greater of 50 percent of annual medical trend or 5 percent. The insurer would be allowed to file for approval of an actuarially justified new business rate for new insureds and a rate increase for existing insureds that is equal to the greater of 150 percent of medical trend or 10 percent. (This is the limit on the total rate increase, as compared to the limit on the portion of the rate increase that is due to the insurer reducing its loss ratio.) Future annual rate increases for existing insurers would be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge.

2. The department would disapprove a rate increase that is in excess of the greater of 150 percent of medical trend or 10 percent if the insurer or HMO did not comply with the annual rate filing requirements. The insurer would be allowed to file for approval of an actuarially justified new business rate for new insureds, and a rate for existing insureds subject to the specified limit. Future annual rate increases for existing insurers would be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge.

3. The department would disapprove a rate increase that is in excess of the greater of 150 percent of annual medical trend or 10 percent for a policy form or block of pooled forms which are not currently available for sale.

The bill provides that if a rate filing changes the established rate relationship between insureds, the aggregate effect must be revenue neutral and the change must be phased in over a period not to exceed 3 years, as approved by the department.

The department would be required to semiannually determine, by rule, medical trend for each health care market, as specified in the bill, using reasonable actuarial techniques and standards. The department would be required to survey insurers and HMOs representing at least an 80 percent market share for each of the specified health care markets, in order to compute the average annual medical trend.

Section 3 amends s. 627.6487, Guaranteed availability of individual health insurance coverage to eligible individuals.

The bill changes the two policy forms that must be offered by individual health insurers to "HIPPA-eligible" individuals. Instead of being required to offer their two most popular policy forms, the bill would require individual health insurers to offer the standard and basic policy that small group carriers are required to offer to small employers under s. 627.6699, F.S. This provision is intended to eliminate the incentive for carriers to reduce the benefits that are included in their two most popular policy forms.

The bill also prohibits individual carriers from applying discriminatory underwriting and rating practices to HIPAA-eligible individuals. By allowing nondiscriminatory underwriting and rating practices to be applied, the bill would permit an insurer to impose a premium surcharge on a HIPAA-eligible person due to a particular health condition, if the insurer imposes the same surcharge on other non-HIPAA-eligible persons applying for coverage who have the same medical condition. In other words, an insurer could not impose a surcharge on HIPAA-eligible persons due to their HIPAA-eligibility status alone.

Section 4 amends s. 627.6515, F.S., Out-of-state groups. The bill provides an exception to the provision that group certificates issued to Florida residents under a group policy issued outside of Florida are exempt from most provisions of Florida's insurance laws. The bill provides that if the insurer requires individual underwriting to determine coverage eligibility or premium rates to be charged, the group certificate issued in Florida would be subject to the same requirements of the Insurance Code that apply to individual health insurance policies issued in Florida. (The bill makes conforming changes to s. 627.410, F.S., above) This would require that group certificates issued in Florida comply with all mandatory benefits and rate filing laws that currently apply to individual health insurance policies, if the insurer requires individual underwriting to determine eligibility or premiums.

Section 5 amends s. 627.6699, Employee Health Care Access Act. The bill would make the following changes:

Small group carriers would be permitted to separate the experience of their one-life groups (employers with one employee, sole proprietors, and self-employed individuals) into a separate rating pool, apart from the rating pool for their small employer groups with 2-50 employees. Therefore, with certain limitations, the claims experience of the one-life groups would be the basis for establishing the rates for one-life groups and would not impact the rates for the 2-50 employee groups, which would be based on its own experience. However, the rate charged to the one-life groups could not exceed 150 percent of the rate determined for the groups of 2-50 employees. For one-life groups insured on July 1, 2001, the rate may be up to 125 percent of the rate for the groups of 2-50 employees for the first annual renewal and 150 percent for subsequent annual renewals. (This provision controls over any lower limit that would be imposed under s. 627.411, F.S., as amended above.) The carrier would be permitted to charge any excess losses of the one-life group pool to the experience pool of the 2-50 employees.

The bill also provides that small group carriers could only provide credits (not surcharges) due to duration of coverage (the time period that a small employer has been insured with the carrier).

Section 6 amends s. 627.6741, F.S., Issuance, cancellation, nonrenewal, and replacement.

The bill requires that Medicare supplement insurers offer such policies on a guaranteed-issue basis, without regard to health status and without discrimination in the price, to any individual who is under 65 years of age and eligible for Medicare by reason of disability. This offer of coverage must be made during the 6-month period beginning with the first month in which the individual is eligible for Medicare by reason of disability and is enrolled in Medicare part B. This would provide the same 6-month open enrollment period for persons who are eligible for Medicare by reason of disability, as the current law provides for persons who are eligible for Medicare by reason of age. The bill provides an exception to the new guarantee-issue requirement, which would not apply to end-stage renal disease beneficiaries.

For individuals who are otherwise eligible for guarantee-issue of coverage under the bill, but who first enrolled in Medicare part B before July 1, 2001, the 6-month period would begin on July 1, 2001. A Medicare supplement policy issued on a guarantee-issue basis to an individual who is eligible for Medicare by reason of disability must be issued at the premium rate for persons 65 years of age.

Section 7 amends s. 627.9408, F.S., Rules. The bill amends the Long-Term Care Insurance Act to authorize the department to adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners (2nd quarter of 2000), which are not in conflict with the Florida Insurance Code. The provisions of the model that are perceived to be of most importance, which the department is expected to adopt, are those provisions intended to prevent insurers from implementing large rate increases after a policy has been issued. See, Present Situation, above, for a summary of the NAIC Model Regulations.

Section 8 amends s. 641.31, F.S., Health Maintenance Contracts. The bill amends the law relating to rate filings for HMO contracts to exempt from rate filing and approval requirements group HMO contracts insuring groups of 51 or more persons, except for any coverage where the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium. (This conforms to the bill's amendments to s. 627.410, F.S., for health insurance policies).

The bill also provides that the grounds for disapproval of an HMO rate filing would be those specified in s. 627.411, F.S., which are the grounds for disapproval of a rate filing by a health insurer.

Section 9 provides that the act shall take effect July 1, 2001.

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:

Those insurers that market individual coverage certificates in Florida under out-of-state group polices will be required to comply with Florida law governing benefits and rates for individual policies issued in Florida. These insurers may incur increased regulatory costs. According to a department informal survey among insurers, rate filing costs can range from $1,000 to $8,000, with an average cost of about $3,000.

Florida residents covered under out-of-state group policies would be afforded greater protection against "death spiral" rating practices and would receive all mandatory health insurance benefits required for individual policies. It is likely that the initial premium for such polices is will be greater, but future rate increases would be smaller. However, representatives of insurers that market out-of-state group policies claim that many insurers will choose not to sell coverage in Florida if they are subjected to Florida laws.

There will be a one-time regulatory cost to insurers issuing individual health insurance policies that must make new filings to comply with the requirement to offer the standard and basic policies to HIPAA-eligible individuals.

The allowance for small group carriers to establish a separate rating pool of one-life groups could increase rates by as much as 50 percent for some one-life groups, according to the department, but this would be offset by rate decreases for groups of 2-50 employees.

Changes to the rate filing laws are expected to reduce rate filing costs, particularly for large group policies, which would be exempt from these requirements. For policies that remain subject to rate filing requirements, insurers are provided clearer standards for what would be allowed as an "automatic increase" and what would trigger department disapproval.

Persons who are eligible for Medicare by reason of disability would be entitled to purchase a Medicare supplement policy that covers certain expenses not covered by Medicare. Insurers issuing such policies would be subject to potential losses, due to adverse selection.

By authorizing the department to adopt the NAIC Long-Term Care Insurance Model Regulation, the bill affords greater protection to policyholders who purchase long-term care

insurance policies in the future against large rate increases. Such policyholders would be provided a contingent benefit upon lapse of the policy due to nonpayment of premium, after a rate increase of a certain amount.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.