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**HOUSE OF REPRESENTATIVES**
**COMMITTEE ON**
**HEALTH PROMOTION**
**ANALYSIS**

**BILL #:** HB 1439

**RELATING TO:** Health Insurance

**SPONSOR(S):** Representative(s) Berfield

**TIED BILL(S):**

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

(1) HEALTH PROMOTION
(2) FISCAL POLICY & RESOURCES
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

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I. SUMMARY:

HB 1439 revises various provisions of the Florida Insurance Code relating to health insurance. The bill:

- Requires certain out-of-state group certificates for health insurance coverage to be subject to the requirements for individual health insurance policies issued in this state;
- Exempts large group health insurance policies (those issued to groups with 51 or more employees) from prior approval of the Department of Insurance rates and forms filing requirements;
- Provides alternative rate filing requirements for insurers with less than 1,000 nationwide policyholders or members;
- Revises the grounds for the disapproval of insurance policy forms;
- Provides that a heath insurance policy form may be disapproved if it results in certain rate increases;
- Specifies allowable new business rates and renewal rates if rate increases exceed certain levels;
- Authorizes the Department of Insurance to determine medical trend for purposes of approving rate filings;
- Revises the types of policies that individual health insurers must offer to persons eligible for guaranteed individual heath insurance coverages;
- Prohibits individual health insurers from applying discriminatory underwriting or rating practices to eligible individuals;
- Requires coverage issued to a state resident under certain group health insurance policies issued outside the state be subject to the requirements for individual health insurance policies;
- Revises definitions of “established geographic area” and “modified community rating” as used in the Employee Health Care Access Act;
- Allows carriers to separate the experience of small employer groups with fewer than two employees;
- Revises the rating factors that may be used by small employer carriers;
- Requires that insurers offer Medicare supplement policies to individuals eligible for Medicare by reason of disability and under 65 years of age;
- Authorizes the Department of Insurance to adopt, by rule, certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners;
- Exempts contracts of group HMOs covering a specified number of persons from the requirements of filing with the Department of Insurance;
- Specifies the standards for the Department of Insurance approval and disapproval of a change in rates by an HMO; and
- Provides alternative rate filing requirements for organizations with less than a specified number of subscribers.

The bill’s effective date is July 1, 2001.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

Less Government: Requires out-of-state insurers to meet the same filing requirements as required of in-state insurers.

B. 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 ss. 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. (Rule 4-149, Florida Administrative Code) 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 its health insurance rating rules, which have been the subject of continuing legal challenges. One recurring issue has been 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 with the department 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 grants the department 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, which are separately 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 in the same manner 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., prior to the 2000 Legislative session, required 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 require 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 Financing 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 (s. 627.6699, F.S.).

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 s. 627.6675 or s. 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.

[**Note:** The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986. The law requires that most employers who sponsor group health insurance plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.]

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.

Section 627.6741, F.S., requires insurers issuing Medicare supplement insurance to 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 in the model 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 address this issue by allowing greater freedom to insurers to establish the initial rate and providing stronger state 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 market.

C. EFFECT OF PROPOSED CHANGES:

HB 1439:

- Requires certain out-of-state group certificates for health insurance coverage to be subject to the requirements for individual health insurance policies issued in this state;

- Exempts large group health insurance policies (those issued to groups with 51 or more employees) from prior approval of the Department of Insurance rates and forms filing requirements;
- Provides alternative rate filing requirements for insurers with less than 1,000 nationwide policyholders or members;
- Revises the grounds for the disapproval of insurance policy forms;
- Provides that a heath insurance policy form may be disapproved if it results in certain rate increases;
- Specifies allowable new business rates and renewal rates if rate increases exceed certain levels;
- Authorizes the Department of Insurance to determine medical trend for purposes of approving rate filings;
- Revises the types of policies that individual health insurers must offer to persons eligible for guaranteed individual heath insurance coverages;
- Prohibits individual health insurers from applying discriminatory underwriting or rating practices to eligible individuals;
- Requires coverage issued to a state resident under certain group health insurance policies issued outside the state be subject to the requirements for individual health insurance policies;
- Revises definitions of "established geographic area" and "modified community rating" as used in the Employee Health Care Access Act;
- Allows carriers to separate the experience of small employer groups with fewer than two employees;
- Revises the rating factors that may be used by small employer carriers;
- Requires that insurers offer Medicare supplement policies to individuals eligible for Medicare by reason of disability and under 65 years of age;
- Authorizes the Department of Insurance to adopt, by rule, certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners;
- Exempts contracts of group HMOs covering a specified number of persons from the requirements of filing with the Department of Insurance;
- Specifies the standards for the Department of Insurance approval and disapproval of a change in rates by an HMO; and
- Provides alternative rate filing requirements for organizations with less than a specified number of subscribers.

D. SECTION-BY-SECTION ANALYSIS:

**Section 1.** Amends section 627.410, F.S., relating to filing and approval of forms by the Department of Insurance, as follows:

Subsection (1) is amended to require that group certificates for health insurance coverage, as described in s. 627.6561(5)(a)2., F.S., relating to preexisiting conditions, requiring individual underwriting to determine coverage eligibility or premium rates to be charged, must be considered policies issued on an individual basis and are subject to and must comply with the Florida Insurance Code in the same manner as individual health insurance policies in this state.

Subsection (6)(a) 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 increased claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

Subsection (7) is amended to add as a new paragraph (f) 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), F.S., as amended by the bill (below). These provisions would not apply to Medicare supplement insurance.

**Section 2.** Amends s. 627.411(1)(e), F.S., relating to the Department of Insurance's grounds for disapproval of health insurance products, as follows:

Subparagraph 1. and 2. are amended to incorporate scrivener's revisions.

Subparagraph 3 is amended to delete the provision that allows 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 as set forth in s. 626.9541(1)(g)2., F.S., relating to unfair discrimination between individuals of the same actuarially supportable class and essentially the same hazard.

Subparagraph 4. is added providing that the department would disapprove a rate increase that results in an actuarially justified rate increase that includes the insurer reducing the portion of the premium used to pay claims from the loss-ratio standard certified in the last actuarial certification filed by the insurer, which rate increase is in excess of the actuarially justified rate increase without a loss-ratio change, by an amount exceeding the greater of 50 percent of annual medical trend or 5 percent.

Subparagraph 5. is added providing that the department would disapprove a rate increase that results in an actuarially justified rate increase that includes the insurer changing established rate relationships between insureds or types of coverage, which rate increase is in excess of the actuarially justified rate increase without such relationship change, to any insured by an amount exceeding the greater of 50 percent of annual medical trend or 5 percent.

Subparagraph 6. is added providing that the department would disapprove a rate increase that results in an actuarially justified rate increase that is in excess of the greater of 150 percent of annual medical trend or 10 percent attributed to the insurer not complying with the annual filing requirements of s. 627.410(7), F.S., relating to filing and approval of forms, or a departmental rule adopted under s. 641.31, F.S., relating to health maintenance contracts.

Subparagraph 7. is added providing that the department would disapprove a rate increase that results in an actuarially justified rate increase that is in excess of the greater of 150 percent of annual medical trend or 10 percent on a form or block of pooled forms in which no form is currently available for sale.

Subsection (3) is created to provide that if, at the time of the rate filing, the renewal rate increase to existing insureds would exceed the indicated levels based on the conditions in subparagraph (1)(e)4. (as provided above), subparagraph (1)(e)5., (as provided above), or subparagraph (1)(e)6. (as provided above), the insurer may file for approval of a higher new business rate schedule for new insureds and a rate increase of the amount that is actuarially justified by the aggregate data without such condition, plus the greater of 50 percent of annual medical trend or 5 percent for existing insureds. Limits future annual rate increase for existing insureds at the time of the exercise of this provision to the greater of 150 percent of the rate increase approved for new insured, the greater of 150 percent of medical trend, or 10 percent, until the rate schedules converge. Provides that the application of this subsection does not violate s. 627.410(6)(d), F.S., relating to prohibiting certain rating practices.

Subsection (4) is created to provide that if a rate filing changes the established rate relationship between insureds, the aggregate effect of the change must be revenue neutral. Provides that the

change to the new relationship must be phased in over a period not to exceed 3 years, as approved by the department.

Subsection (5) is created to provide that in determining medical trend for application of subparagraphs (1)(e)4., 5., 6., and 7. (as provided above), the department shall, semiannually, determine medical trend for each health care market, using reasonable actuarial techniques and standards. Requires that the trend must be adopted by the department by rule and determined as follows:

Paragraph (a) requires that trend must be determined separately for medical expense; preferred provider organization; and other coverage for individual, small group, and large group where applicable.

Paragraph (b) requires the department to survey insurers and health maintenance organizations currently issuing products and representing at least an 80-percent market share based on premiums earned in the state for the most recent calendar year for each of the categories specified in paragraph (a).

Paragraph (c) requires trend to be computed as the average annual medical trend approved for the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.

Paragraph (d) provides that the annual trend is the annual change in claims cost per unit of exposure. Trend includes the combined effect of medical provider price changes, new medical procedures, and technology and cost shifting.

**Section 3.** Amends s. 627.6487, F.S., guaranteed availability of individual health insurance coverage to eligible individuals, as follows:

Paragraph (4)(b) is amended to provide that the requirement of this subsection regarding the offering of forms is met if the issuer offers the basic and standard health benefit plans as established pursuant to s. 627.6699(12), F.S., relating to the Employee Health Care Access Act. Deletes requirements for offering policy forms for individual health insurance coverage with the largest, and next to largest premium volume offered by the issuer or as otherwise specified.

Paragraph (8)(a) is amended to specify that this section does not restrict individual carriers from applying discriminatory underwriting and rating practices to federal Health Insurance Portability and Accountability Act (HIPPA) eligible individuals. [**Note:** By allowing nondiscriminatory underwriting and rating practices to be applied, the bill permits 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., relating to out-of-state groups, to add as a new subsection (9) 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. 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 the state.

**Section 5.** Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, as follows:

Amends subsection (3), relating to definitions, as follows:

Amends paragraph (3)(i), - "established geographic area" to mean the county or counties, but not portion of a county, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers by deleting language referring to "any portion of a county or counties."

Amends paragraph (3)(n) - "modified community rating", deleting rating factors for claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5. Authorizes a carrier to separate the experience of small employer groups with less than two eligible employees from the experience of small groups with two through 50 eligible employees.

Amends subsection (6), relating to restrictions relating to premium rates, as follows:

Amends paragraph (b) by adding subparagraph 3., to provide that if the modified community rate is determined from two experience pools, as authorized in paragraph (5)(n), then the rate to be charged to small employer groups of less than two eligible employees may not exceed 150 percent of the rate determined for groups of two through 50 eligible employees. However, a carrier may charge excess losses of the less-than-two-eligible-employee experience pool to the experience pool of the two through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less-than-two-eligible-employee experience pool is maintained.

Renumbers current subparagraph 3. as 4.

Renumbers current subparagraph 4. as 5.

Renumbers current subparagraph 5. as 6. and deletes the following provisions:

- Prohibition of charging individual employees or dependents adjustments in rates for experience, health status, or duration of coverage.
- Limitation of such adjustments of a small employer's policy which result in a rate which deviates more than 15 percent from the carrier's approved rate.
- Limitation of adjustment to a small employer's renewal premium, not to exceed 20 percent annually, due to claims experience, health status, or duration of coverage of the employees or dependents of the small employer.
- Requirement for semi-annual report by small group carriers specific information to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates.
- Limitation of application of adjustment to only minus adjustments beginning not more than 60 days after the report is sent to the department if the aggregate resulting from the application exceeds the premium that would have been charged by application of the approved community rate by 5 percent for the current reporting period.
- Limitation for any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments.

Renumbers the remaining subparagraphs.

**Section 6.** Amends s. 627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement, as follows:

Amends paragraph (1)(a), relating to insurers issuing Medicare supplement policies in this state, to expand eligible enrollees of such policies to include any individual under 65 years of age and eligible for Medicare by reason of disability, who resides in this state, 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.

Amends paragraph (b), to provide conforming language to include individuals under 65 years of age and eligible for Medicare by reason of disability.

Provides that paragraphs (a) and (b) do not apply to end-stage renal disease beneficiaries before they attain 65 years of age. Provides that for those individuals who are eligible under paragraph (a) or (b) who first enroll in Medicare part B before July 1, 2001, the 6-month period shall begin on July 1, 2001. Provides that a Medicare supplemental policy issued to an individual under (a) or (b) who is less than 65 years of age and who is eligible for Medicare by reason of disability shall be issued at a premium rate for persons 65 years of age.

**Section 7.** Amends s. 627.9408, F.S, relating to rules, as follows:

The existing provision is designated as subsection (1) and the bill makes permissive the authority of the department to adopt rules and administer those rules relating to this part.

Adds subsection (2), 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 in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

**Section 8.** Amends s. 641.31(3), F.S., relating to health maintenance contracts, as follows:

Amends paragraph (b), relating to changes in rates, to provide that this paragraph does not apply to a group contract covering 51 or more persons unless the rate is for any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

Amends paragraph (d) to make a grammatical change and to provide the statutory cross-reference to grounds for disapproval by the department.

Adds paragraph (f) to provide that an HMO with fewer than 1,000 covered subscribers under all individual or group contracts, at the time of rate filing, may file for an annual rate increase limited to annual medical trend, as adopted by the department. Provides that the filing is in lieu of the actuarial memorandum otherwise required for the rate filing. Provides that the filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

**Section 9.** Provides an effective date of July 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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 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.

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 an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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

This bill does not reduce the authority that counties or municipalities have to raise revenues.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

According to the Department of Insurance,

> [T]he state of Florida's health insurance market is such that it either cannot meet the needs of those it serves or it offers them very little in the way of protection. Revitalizing that market requires action on many fronts. We must take important steps to positively impact the individual small group and large group markets with initiatives that reward responsible behaviors, help people maintain their coverage, and provide options for the uninsured.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

| Prepared by: | Staff Director: |
| --- | --- |
| Tonya Sue Chavis, Esq. | Phil E. Williams |