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/CS/SB's 1960 and 1760

SPONSOR: Health, Aging and Long-Term Care Committee, Banking and Insurance Committee, and Senators Latvala and King

SUBJECT: Health Care

DATE: April 24, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.	Liem	Wilson	HC	Favorable/CS
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

The bill makes the following changes affecting health care insurance:

1. Creates a pilot program to provide health care coverage for uninsured, low-income persons, referred to as health flex plans. The Agency for Health Care Administration (Agency) and the Department of Insurance (Department) could approve health flex plans in the three areas of the state having the highest number of uninsured residents, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. Such plans would be exempt from the requirements of the Insurance Code.

2. Expands the definition of a "limited benefit policy or contract" that could be offered to either small or large employers that would be exempt from mandatory benefits that normally apply to health insurance policies or HMO contracts.

3. Reopens the Florida Comprehensive Health Association (FCHA) for enrollment on January 1, 2002, caps new enrollment in the association at 500 for calendar year 2002 and allows an additional 1,500 members, effective January 1, 2003, and makes changes to procedures, structure and eligibility for the program.

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

5. Exempts from rate filing requirements group health insurance policies and HMO contracts insuring groups of 51 or more persons, with certain exceptions.

6. Exempts from annual rate filing requirements insurance policy forms with fewer than 1,000 nationwide policyholders or members and allows for an annual rate increase limited to medical trend.

7. Establishes specific actuarial criteria for rate disapproval and deletes the provision that allows the Department to disapprove health insurance rates "which result in premium escalations that are not viable for the policyholder market."

8. Allows carriers writing individual policies to offer "HIPAA-eligible" individuals the standard and basic policy that small group carriers are required to offer, as an option to offering 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.

9. Allows small group carriers 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).

10. 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, 627.6482, 627.6486, 627.6487, 627.6488, 627.649, 627.6492, 627.6498, 627.6515, 627.6699, 627.9408, and 641.31, F.S., repeals s. 627.6484, F.S., and creates three undesignated sections of law.

II. Present Situation:

Florida Health Insurance Statistics

According to the 1999 Florida Health Insurance Study (FHIS)[1] published by the Agency for Health Care Administration, while the Florida population has increased steadily through the 1990s the number of uninsured Floridians has fallen from 2.6 million or 18.5 percent of the population (RAND 1993) to 2.1 million or 16.8 percent of the population (FHIS 1999). The uninsured are heavily concentrated in certain regions of the state, where they are putting significant stress on "safety net" health care providers.

[1] http://www.fdhc.state.fl.us/Publications/FHIS/index.shtml

According to the FHIS, the uninsured are best defined by four characteristics: income, employment status, ethnicity, and region of the state. When considering Florida's uninsured rate (under age 65), no single factor plays a greater role than income. Nearly half of the uninsured earn less than 150 percent of the federal poverty level ($25,575 annual income for a family of four). About 58 percent of the uninsured earn less than 200 percent of the federal poverty level.

The 34 percent rate of uninsurance for the population earning less than 150 percent of the federal poverty level is more than twice the statewide average, and nearly four times the 8.6 percent rate of uninsurance for those earning more than 250 percent of the poverty level ($42,625 annual income for a family of four). By far the most commonly cited answer to the question, "What is the main reason that you do not have health insurance?" was "Too expensive/can't afford it/premiums too high." This answer was cited by 74 percent of the respondents.

The areas with the highest percentage of uninsured are District 13 at 25.5 percent (De Soto, Glades, Hardee, Hendry, Highlands, Monroe and Okeechobee), District 17 at 24.6 percent (Dade), and District 14 at 19.8 percent (Charlotte, Collier, and Lee). In Dade County, nearly 43 percent of those earning less than 150 percent of the federal poverty level are uninsured.

According to a Kaiser Family Foundation study published in September 2000, many workers and retirees dependent on employer-sponsored health insurance are likely to face significant premium increases in the near future. The anticipated premium hikes come in addition to an average increase of 8.3 percent in 2000, and both are driven largely by higher costs for care, including prescription drug costs. The report, based on a survey of 3,402 employers nationwide, predicted that premiums will continue to go up and that "employers may respond to the rising cost of health insurance [by passing] some portion of the increased cost on to employees." In interviews, managers of companies large and small, as well as health insurance analysts, indicated that many workers can expect to pay even bigger percentages in the future, especially in a weak economy.

Health Insurance Regulation

A person or entity must obtain a certificate of authority (COA) from the Department of Insurance in order to transact health insurance in this state.

The Department may not grant a COA if it finds the management, officers, or directors to be incompetent or untrustworthy or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or which it has good reason to believe are affiliated with any person whose business operations are to the detriment of policyholders, stockholders, investors, or of the public, by manipulation of assets, accounts, or reinsurance, or by bad faith. The Department may deny a COA if any person who exercises or has the ability to exercise effective control of the insurer, or who has the ability to influence the transaction of the business of the insurer, has been found guilty of, or has pleaded guilty or nolo contendere to any felony.

Before an insurer may be issued an original COA it must maintain a minimum amount of surplus as to policyholders, equivalent to a net worth requirement. Under s. 624.407, F.S., for a health insurer, the minimum surplus is the greater of $2.5 million or 6 percent of total liabilities requirement.

The maximum amount of insurance that an insurer may write is controlled by its surplus as to policyholders. Section 624.4095, F.S., sets maximum ratios of premiums written to surplus as to policyholders. The basic ratio is 10 to 1 for gross written premiums and 4 to 1 for net written premiums ("gross premiums written" includes premiums that are reinsured, "net" does not). These ratios are modified for certain kinds of insurance. For health insurance, premiums may not be more than 3.2 times surplus.

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom of choice selections of health care providers and health care related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional who is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

Under present law, the Department regulates HMO finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from the Department, an HMO must receive a Health Care Provider Certificate from the Agency. Any entity that is issued a certificate under part III of chapter 641, F.S., and that is otherwise in compliance with the licensure provisions under part I, may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

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 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 that 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 its 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.]

Each health insurer 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.

Florida Comprehensive Health Association Eligibility, Benefits, and Premiums

As enacted under chapters 82-243 and 82-386, Laws of Florida, the FCHA provides health insurance to individuals who, due to their health status or inability to afford coverage, are unable to obtain health insurance coverage in the private market. The FCHA was created as a nonprofit, legal entity subject to the supervision of a three-member board of directors, appointed by the Insurance Commissioner. The board includes the chairman, who is the Insurance Commissioner or a designee, 1 representative of policyholders, and 1 representative of insurers. Presently, an independent agent serves as a representative of the insurers, as compared to a representative of an insurer selected in the past.

Throughout the early years of the program, enrollment and insurance fund losses were low; however, by 1989, enrollment and losses had increased substantially. Legislation was enacted to prohibit the FCHA from issuing policies to new applicants after July 1, 1991. The FCHA currently provides coverage for 702 individuals. According to representatives of FCHA, enrollment is declining at a rate of approximately 15 percent per year.

Some uninsured individuals in Florida voluntarily elect to not maintain health insurance coverage. However, a significant segment of the medically uninsured desire coverage, and would be willing to pay higher premiums, if coverage were at all available. The FCHA notes that 34 percent of the current association enrollees have a household income of $40,000 or more, indicating that the cost of premiums may not be the sole barrier to entry. The FCHA estimates potential new enrollees in the association at 3,700 - 6,200 individuals

Effective July 1, 1990, the FCHA was amended to require the FCHA to pattern its coverage after the state group health insurance program including benefits, exclusions, and other limitations, except as otherwise provided by law. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The FCHA provides for an annual deductible in the amount of $1,000 or more, as approved by the Department of Insurance. The FCHA provides for a 12-month exclusion of insurance coverage with respect to a condition that manifested itself within 6 months of the effective date of the coverage or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage.

A precondition for FCHA eligibility is that the applicant be rejected by at least 2 insurers offering coverage substantially similar to the FCHA's coverage and the market assistance plan has been unsuccessful in finding an insurer to accept the application. Rejection is defined as an

offer of coverage with a material underwriting restriction or an offer of coverage at a rate greater than the FCHA's rate. Therefore, the rejection may or may not be due to a determination that an applicant is literally uninsurable.

Legislative changes in 1990 required the FCHA board or administrator to verify the residency of an applicant and to prohibit the enrollment of a person who is eligible for Medicaid, unless: such person has an illness or disease that requires supplies or medication that are covered by the FCHA, but that are not covered by the Medicaid program; or the person is not receiving benefits under Medicaid. In addition, the law was clarified to allow FCHA to terminate an enrollee immediately if the enrollee ceases to meet the eligibility requirements.

The Department of Insurance annually establishes the standard risk rate that is used for determining premiums for the FCHA under s. 627.6498(4)(a), F.S. Under s. 627.6675, F.S., the Department uses reasonable actuarial techniques and standards adopted by rule. As currently provided, the maximum rates for the FCHA are 200 percent, 225 percent, and 250 percent of this standard risk rate for low, medium, and high-risk individuals, respectively.

According to the FCHA, the standard risk rate that is established by the Department is compared to the rates approved by the FCHA and the FCHA actuary recommends whether adjustments are necessary. The FCHA submitted its last rate filing with the Department in 2000 and that rate filing was effective January 1, 2001. The FCHA currently has no rate filing pending.

Florida Comprehensive Health Association Assessments

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, health maintenance organizations, fraternal benefit societies, multiple employer welfare arrangements, and prepaid health clinics. Self-funded employers and governmental entities are not subject to the assessment.

The board assesses each insurer annually a portion of incurred operating losses of the FCHA, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments per participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied.

Closure of the Florida Comprehensive Health Association

The FCHA ceased accepting applications on July 1, 1991, under s. 627.6484(1), F.S., due to the Legislature's concern over mounting financial losses. At that time, 2 actuarial firms estimated the 1992 deficit of the FCHA to be between $48 and $56 million, as compared to the maximum $27 million that could be assessed against insurers under the funding formula enacted in 1990. In 1991, legislation revised the funding formula providing for maximum assessments against the insurers of 1 percent of health insurance premiums written in Florida under s. 627.6492(1)(b), F.S.

In the Summary of Plan Activities, 1997-98, the FCHA offered the following solutions to provide coverage for the uninsured:

- Open enrollment for the state's high-risk pool, the FCHA;
- Guarantee issue by individual insurers and health maintenance organizations;
- Expansion of the small group market guarantee-issue requirement;
- Allow uninsurable individuals access to the State Employee Health Insurance Plan;
- Allow access to Medicaid, regardless of income status; or
- Allow alternative sources of funding for FCHA.

The report "strongly recommended" that, if the FCHA were to be reopened, funding would need to be addressed to effectively finance the high-risk pool. The report suggested the following funding options:

- Appropriate General Revenue monies;
- Create another business tax;
- Increase sales tax;
- Provide premium tax offset for assessment;
- Raise risk-pool premiums;
- Tax hospital revenues;
- Place service charge on hospitals and surgical centers;
- Assess health insurance policyholders; or
- Increase taxes on cigarettes, alcohol or other products.

Twenty states fund risk pools by assessing association members. Other states provide funding through one or more sources, such as: state income tax, tobacco tax, general revenue, and tobacco settlement funds (California, Colorado, Louisiana, Kentucky, Utah, and Wisconsin). Louisiana appropriates funds from general revenue and imposes a service charge on hospital admissions and outpatient procedures.

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 enrollment 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.

Small group carriers are required to offer the *standard health benefit plan* and the *basic health benefit plan* to each small employer applying for coverage. The act lists certain benefits that must be included in each of these policies. The act also authorizes the appointment of a health benefit plan committee to recommend to the Department additional provisions for the plans which were incorporated into the standard and basic policies. In addition, a *limited benefit policy or contract* may be offered by a small employer carrier, which is a policy or contract providing coverage for named insureds for a specific named disease, accident, or limited market such as the small group market. Small employer carriers offering coverage under limited benefit policies or contracts must make certain disclosures to small employer groups including, explaining the mandated benefits and providers not covered under the policy or contract; explaining the managed care and cost control features of the policy or contract; and explaining the primary and preventative care features of the policy or contract.

The act provides that the standard, basic, and limited benefit plans are exempt from any law requiring coverage for a specific health care service or benefit, or any law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, unless that law is made expressly applicable to such policies or contracts.

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 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.

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.

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:

Legislative Findings and Intent. The bill includes "Whereas" clauses stating that the Legislature recognizes that the increasing number of uninsured Floridians is due in part to small employers' and their employees' inability to afford coverage and the need to have the opportunity to choose more affordable plans. It is the intent of the Legislature that insurers and HMOs have maximum flexibility in health plan design or in developing a health plan design to complement a medical savings account program established by a small employer for the benefit of its employees.

Section 1. Creates a pilot program to provide health care coverage for uninsured, low-income persons, referred to as *health flex plans*.

A legislative finding is made that a significant portion of Floridians are not able to obtain affordable health insurance and that it is the intent of the Legislature to expand the availability of health care options for lower-income uninsured Floridians by encouraging health insurers, HMOs, health care provider-sponsored organizations, local governments, health care districts, and other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventative health care services.

The Agency and the Department are authorized to jointly approve health flex plans that provide health care coverage for eligible participants in the three areas of the state having the highest number of uninsured residents as determined by the Agency. Such plans could be offered by any *health plan entity* defined to mean a health insurer, HMO, health care provider-sponsored organization, local government, health care district, or other public or private community-based organization that develops and implements an approved plan and is responsible for financing and paying all claims by enrollees of the plan. A health flex plan may limit or exclude benefits otherwise required by law, cap the total amount of claims paid in 1 year per enrollee, or limit the number of enrollees covered.

The Agency and Department may not approve a plan that:

- contains any ambiguous, inconsistent, or misleading provisions;
- provides benefits that are unreasonable in relation to the premium charged;
- contains provisions that are unfair or inequitable or contrary to the public policy of this state;
- results in unfair discrimination in sales practices; or
- cannot demonstrate that the plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

Other than approval by the Agency and Department, no licensure under the Insurance Code would be required for an approved health flex plan. The plan would be exempt from all

provisions of the Insurance Code unless made expressly applicable, except that the Unfair Insurance Trade Practices of part IX of chapter 626, Florida Statutes, would apply except where in conflict with the provisions of this section.

In order to be eligible to enroll in an approved flex plan, a person must:

- be a Florida resident;
- be 64 years of age or younger;
- have a family income equal to or less than 200 percent of the federal poverty level;
- not be covered by private insurance, not be eligible for Medicare or Medicaid or other public health care program, and not have been covered at any time during the preceding 6 months.

A health flex plan entity must maintain reasonable records of its loss, expense, and claims experience, which must be available to the Agency and the Department.

Any denial of coverage, nonrenewal, or cancellation of coverage, must be accompanied by the specific reasons for such action. Notice of nonrenewal or cancellation must be provided at least 45 days in advance, except that 10 days' written notice is required for cancellation due to nonpayment of premiums.

The Agency is authorized to seek any remedy provided by law, including the remedies provided in s. 812,035, F.S., if the Agency finds that a health plan entity has engaged in any act resulting in injury to an enrollee covered by an approved health flex plan. The provisions of s. 812.035, F.S., currently authorize a circuit court to enjoin violations of ss. 812.012-812.037, F.S., (theft, robbery, and related crimes) by issuing a wide range of specified orders and judgments.

Section 2. Amends s. 627.410, F.S., relating to filing and 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 for the individual, 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), F.S., as amended by the bill (below). These provisions would not apply to Medicare supplement insurance.

Section 3. Amends s. 627.411, relating to grounds for disapproval. The bill deletes 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. 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 4. Amends subsections (4) and (8) of s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals.

The bill revises the policy forms that must be offered by individual health insurers to "HIPPA-eligible" individuals. As an option to the current requirement that the insurer offer its two most popular policy forms, the bill would allow the insurer to offer the standard and basic policy that small group carriers are required to offer to small employers under s. 627.6699, F.S.

The bill 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 5. Amends s. 627.6482, F.S., to delete obsolete portions of the definition of the term "Premium" for the FCHA. The bill defines the term "Federal Poverty Level" as the most current federal poverty guidelines as established by the federal Department of Health and Human Services and published in the Federal Register, and in effect on the date of the policy and its annual renewal. The term "Family income" is defined as the adjusted gross income, as defined in s. 62 of the United States Internal Revenue Code, of all members of a household.

Section 6. Amends s. 627.6486, F.S., to revise eligibility requirements for the FCHA and delete obsolete language. The amendments require a person to have maintained residency in the state for the previous 6 months to be eligible for benefits. Residency may be demonstrated by purchasing a home and using it as a primary residence for 6 months, or otherwise establishing a domicile in the state for 6 months under s. 222.17, F.S.

Children lose eligibility upon ceasing to be a dependent of the insured. The bill clarifies that a person is no longer eligible if FCHA has paid out the lifetime maximum benefit currently being offered by the association of $500,000 for that person. A person is not eligible for FCHA if the person is eligible for substantially similar coverage under another contract or policy, unless otherwise provided for under s. 627.6692, F.S.

Persons eligible for Medicare are not eligible for coverage under the plan, unless insured by the FCHA and enrolled in Medicare on July 1, 2001. Persons whose premiums are paid for or reimbursed by any government-sponsored program or health care provider are ineligible for coverage under the plan. Persons who are eligible for guaranteed-issuance of coverage under s. 627.2487, F.S. (the Florida law conforming to the federal HIPAA law), would be automatically eligible for coverage in the FCHA unless the association has ceased accepting new enrollees due to enrollment caps. If the FCHA has ceased accepting new enrollees, the eligible individual would revert to the coverage rights in s. 627.6487, F.S., which would entitle the person to obtain an individual health insurer.

A person's coverage ceases: when residency ceases; upon the person's request for termination; upon the death of the covered person; upon any requirement under state law that coverage cease; or 60 days after the person receives an inquiry from the association regarding residency to which the person fails to respond.

All eligible persons must, upon application or renewal, agree to be placed in a case-management system when the association and case manager find that such a system would be cost-effective and provide quality of care to the individual.

Persons may apply for coverage beginning January 1, 2002, for coverage effective April 1, 2002, except for persons insured by the plan as of December 31, 2001, who renew.

Section 7. Amends subsection (3) of s. 627.6487, F.S., to revise the definition of a HIPAA "eligible individual" to exclude persons who are eligible for coverage under the association, unless the association is not accepting new enrollees. If the association is accepting new enrollees, the 63-day period specified in s. 627.6561(6), F.S., is tolled from the time the association receives the application from an individual until such time as the association notifies the individual that it is not accepting and issuing coverage to that individual.

Section 8. Amends s. 627.6488, F.S., to revise the composition of the FCHA's board and to revise the powers and duties of the board. The board is expanded from 3 to 5 members, consisting of the Insurance Commissioner or his designee and 4 other members who must be residents of Florida. One of the members must be a representative of a health insurer or HMO. The Insurance Commissioner or his designee shall serve as the chairperson.

Members and employees of the board are reimbursed, as provided in s. 112.061, F.S., for incurred expenses in carrying out their duties.

The board is responsible for adopting a plan of operation and submitting it to the Department of Insurance for review and approval on an annual basis. The board is also required to adopt internal controls for the operation of the association and provide for an annual audit by an independent certified public accountant licensed under chapter 473, F.S.

It is a requirement of the board to establish a grievance procedure as provided for in ss. 409.7056 and 641.31(5), F.S., for individuals receiving care from an HMO.

The section eliminates the provision currently requiring the board to contract with preferred provider organizations and HMOs and to give consideration to the organizations that contract with the state group health insurance program.

Reporting requirements for the association are revised to coincide with the fiscal year of the association. Reports to the Legislature are to be submitted on March 1 instead of October 1 of each year for the prior fiscal year.

The association is authorized to place an individual with a plan case manager, if it is cost-effective and available in the county where the policyholder resides.

The board is charged specifically with the responsibility of administering the association in a fiscally responsible manner to ensure that the expenses are reasonable in relation to the services provided and that the financial resources are adequate to meet obligations. To assist the board in meeting this objective, the board is required to engage an actuary to conduct an annual evaluation of the actuarial soundness of the association. This evaluation would be conducted at

least annually, but no more often than quarterly. The actuary must determine the feasibility of enrolling new members, based upon the projected revenues and expenses of the association.

The board is given the authority to restrict, at any time, the number of participants in the association, if determined that the revenues will not be adequate to fund new enrollees. If an individual is denied participation solely on the basis of such a determination, the individual must be granted priority for enrollment in the succeeding period in which the association is reopened for enrollment. For calendar year 2002, enrollment in the association is capped at 500. For calendar year 2003, the association may enroll an additional 1,500 persons. Except as provided in s. 627.6486(2)(j), F.S., applications for enrollment must be processed on a first-in, first-out basis.

Procedures must be established by the board to maintain separate accounts and record keeping for policyholders prior to January 1, 2002, and those policyholders issued coverage after that date. The board must appoint an executive director to serve as the chief administrative and operational officer of the association. The association must continue to levy assessments for costs and expenses associated with policyholders insured with the association prior to January 1, 2002.

The board is granted the authority to: appear on its own behalf before governmental agencies; solicit and accept gifts, grants, loans, and other aid; require and collect administrative fees and charges and penalties in connection with transactions; obtain insurance against losses; and contract for necessary goods and services.

Section 9. Amends s. 627.649, F.S., to require agents who are used by FCHA to be licensed by the Department of Insurance to sell health insurance in Florida.

Section 10. Amends s. 627.6492, F.S., to provide that insurers are subject to the current assessment only for those costs and expenses associated with policyholders insured with the association prior to January 1, 2002, including the renewal of coverage for such participants after that date. Obsolete language is eliminated.

For the costs and expenses associated with persons whose coverage begins after January 1, 2002, every insurer is required to pay 25 cents per month for each individual policy or covered group subscriber insured in this state, not including covered dependents, under a health insurance policy, certificate, or other evidence of coverage that is issued for a resident of Florida.

The section defines insurer, for purposes of this provision, to exclude limited-benefit policies, or other types of supplemental policies designed to fill gaps in underlying coverage, personal injury protection coverage provided in a motor vehicle policy, and workers' compensation. The term, insurer, includes third-party administrators and any insurer who provides only administrative services under s. 627.6482(7), F.S. The definition of insurer does not include self-insured employee welfare benefit plans that are not regulated by the Florida Insurance Code under ERISA. The definition of insurer would include multiple employer welfare arrangements as provided for in ERISA. Each covered group subscriber, without regard to covered dependents of the subscriber, would be counted only once with respect to any assessment. The board is required

to allow an insurer to exclude from its number of covered group subscribers those individuals who have been counted by any primary insurer providing coverage pursuant to s. 624.603, F.S.

The calculation of the fee shall be determined as of December 31 of each year and will include all polices and covered subscribers, excluding dependents, insured during any time of the year. The payment is due no later than April 1 of the subsequent year. The first payment is due April 1, 2002, for the period of October 1, 2001, through December 31, 2001. The insurer is required to submit a form with the payment that identifies the number of covered lives for the different insurance products and the number of covered months.

Effective October 1, 2001, the fee may be charged directly by the insurer to each policyholder, insured member, or subscriber and is not part of the premium subject to the Department's review and approval. Nonpayment of the fee would be considered nonpayment of premium for purposes of s. 627.6043, F.S.

Section 11. Amends s. 627.6498, F.S., to require the association to offer an annual, rather than a semi-annual, renewable policy. The section provides that the plan must offer coverage to every eligible person, subject to limitations set by the association, and must pay an eligible enrollee's covered expenses, subject to plan limitations. Only the premium, deductible and coinsurance amounts may be modified, as determined by the board. Holders of association policies issued prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002. Obsolete and redundant language in the section is deleted.

If the coverage is being offered to a HIPAA-eligible individual, as defined in s. 627.6487, F.S., the individual may select the standard or basic benefit plan, as established in s. 627.6699, F.S. The section eliminates the requirement that the coverage offered by the association must be patterned after the state group health insurance program.

Rates are subject to approval by the Department under ss. 627.410 and 627.411, F.S., except as provided by this section. The board is required to revise premium schedules annually, effective January 2002.

The board must establish 3 premium schedules, based upon an individual's income. Schedule A would be applicable to an individual whose family income exceeds the allowable amount for determining eligibility under the Medicaid program, up to and including 200 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 150 percent of the standard risk rate. Schedule B is applicable to an individual whose family income exceeds 200 percent but is less than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 250 percent of the standard risk rate. Schedule C is applicable to an individual whose income is equal to or greater than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 300 percent of the standard risk rate. The Department must determine the standard risk rate and the rate would be adjusted for benefit differences.

The association is required to exclude from policy coverage during the 12 months following the effective date, any preexisting condition that manifested itself within 6 months prior to the effective date, or for which medical advice or treatment was recommended or received within

that 6 months. The preexisting condition provision does not apply to a HIPAA-eligible individual under s. 627.6487, F.S.

The section provides that the FCHA does not provide an individual with an entitlement to health care services or health insurance. A cause of action does not arise against the state, the board or the association for failure to make health services or insurance available under the FCHA.

Section 12. States that the Legislature finds that the provisions of this act fulfill an important state interest.

Section 13. Provides that the amendments in this act to s. 627.6487(3), F.S., will not take effect unless HCFA approves this act as providing an acceptable alternative mechanism, as provided in the Public Health Services Act.

Section 14. Repeals s. 627.6484, F.S., relating to the closure of the FCHA and the Marketing Assistance Program, effective January 1, 2002.

Section 15. Amends s. 627.6515, F.S., relating to 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 to the individual, 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 16. Amends s. 627.6699, the 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).

The bill expands the definition of a "limited benefit policy or contract" that would be exempt from mandatory benefits for other health insurance policies, to include "a policy or contract that fulfills a reasonable need by providing more affordable health insurance." In addition to the current exemption from laws requiring specific health care services or benefits or use of specific health care providers, the bill exempts limited benefit policies from any law restricting or limiting deductibles, co-payments, annual or lifetime maximum payments, unless such law is made expressly applicable to such policy.

The bill further provides that a limited benefit policy may also be offered to an employer with 51 or more employees.

The bill revises the disclosure requirements that a small employer carrier must currently provide to a small employer upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract.

The bill requires the Insurance Commissioner to appoint a new health benefit plan committee before October 1, 2001, and every fourth year thereafter, to determine if modifications to a plan might be appropriate and to submit recommended modifications to the Department for approval. Such determination must be based upon prevailing industry standards regarding managed care and cost containment provisions and be consistent with the low to mid-priced benefit plans offered in the large group market.

Section 17. Amends s. 627.9408, F.S., relating to 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 18. Amends s. 641.31, F.S., relating to 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.

Paragraph (f) is added to s. 641.31, F.S., to provide an exception to the annual rate filing and actuarial memorandum requirement if an HMO has fewer than 1,000 covered subscribers under all individual or group contracts. Such HMOs would be permitted to file for an annual rate increase limited to medical trend as adopted by the Department.

Section 19. Provides that the act shall take effect October 1, 2001.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18 of the Florida Constitution provides that counties and municipalities are not bound by general laws that require them to spend funds or to take an action that requires the expenditure of funds unless the Legislature determines that the law fulfills an important state interest or meets other select exceptions, such as an insignificant fiscal impact. Section 8 provides that the provisions of the act fulfill an important state interest.

There will likely be a fiscal impact, although indeterminate, on cities and counties, unless a city or county administers their own self-insured plan.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Private health insurers and enrollees of private health insurance plans will be subject to an assessment of 25 cents per month for each individual policy or covered group subscriber insured in Florida.

B. Private Sector Impact:

Uninsured persons at or below 200 percent of the federal poverty level who live in one of the “three areas” of the state with the highest rate of uninsurance would be eligible to purchase a health flex plan. It is anticipated that such coverage would be less expensive (and would provide lower benefits) than health insurance or HMO coverage currently available.

Health flex plan entities that are approved by the Agency for Health Care Administration to sell health flex plans are potentially subject to the profits or losses of underwriting such products. The financial ability of the entity to underwrite the plan would be subject to approval of the Agency and Department, for which the bill provides no specific requirements.
By providing a broader definition of a limited benefit policy and a broader exemption from required health insurance benefits, the bill may allow for lower cost, health benefit plans for

both small and large employers. However, employers and their employees who purchase a limited benefit policy may have greater out-of-pocket costs for benefits that are not covered.

The opening of the FCHA would allow HIPPA eligibles and individuals who otherwise are not be able to obtain insurance coverage, due to a determination that they are medically uninsurable, an opportunity to obtain coverage, subject to funding limitations that would limit enrollment, as determined by the board.

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.

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.

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:

According to the Department of Insurance there are 8,572,000 individuals presently insured through employer-sponsored insurance, employer sponsored self-insurance, public sector (federal, state, local government) employer sponsored insurance, self-insurance (administered by a third-party administrator) or non-employer sponsored insurance in Florida. This number was adjusted (divided) by 2.5 percent to determine the estimated number of policies that would be subject to the assessment, to arrive at 3,428,800 policies that would be subject to the assessment. However, the department was unable to provide an estimate of the number of federal employer sponsored insurance or self-insured plans that would not be subject to this assessment.

The first payment of the assessment would be received by the FCHA in April 1, 2002, for the period of October 2001 through December 2001. This three-month period would generate an estimated $10.3 million (or $2.6 million per month) in revenues for the FCHA. On annual basis, it is estimated that the assessment would generate $10,286,400 for the association and provide coverage for an estimated 1,743 - 1,837 individuals.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.