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 1286, 1134, and 1008

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

SUBJECT: Health Insurance

DATE: March 12, 2002 REVISED: _____ _____ _____ _____

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

I. Summary:

This bill makes the following changes to the laws regulating health insurance and HMO contracts:

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 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. Replaces the definition of a “limited benefit policy” with “flexible benefit policy” that could be offered to small employers that would be exempt from mandatory benefits that normally apply to health insurance policies or HMO contracts, unless such mandates are specifically made applicable to flexible benefit policies. All health plan policies offered to a small employer would be exempt from laws limiting deductibles, coinsurance, copayments, and maximum lifetime benefits. A flexible benefit policy may only be offered to a small employer that is not covered by any health insurance and has not been covered during the last 6 months.

3. 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.

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

5. Provides that rate filings for individual health insurance meeting certain criteria could be implemented upon filing with the department, subject to 45-days notice to current insureds. Also establishes specific criteria for rate disapproval in place of the current broad standard requiring disapproval of rates "which result in premium escalations that are not viable for the policyholder market."

6. Authorizes the boards of the two reinsurance pools established for reinsuring HIPAA-eligible individuals and persons covered under small group policies, respectively, to have the authority to establish reinsurance premiums, deductibles, and benefit design, subject to department approval, in place of current statutory requirements.

7. Increases from 30 days to 63 days, the time within which an employee may elect to continue their prior group coverage under the Florida Health Insurance Coverage Continuation Act covering employers with fewer than 20 employees.

8. Allows small group carriers to rate one-life groups, separate from the rating pool for 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.

9. Requires guarantee-issue of coverage to a one-life group within 63 days after the one-life group loses coverage due to its carrier terminating all small group coverage in the state (in addition to the current 31-day open enrollment period in August).

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, which are designed to prevent insurers from implementing large rate increases after a policy has been issued.

11. Revises the information that must be submitted by health insurers to the department, to require specific market information, including premium, number of policies, and covered lives, by market segment.

12. Permits an insurer to nonrenew or discontinue health insurance coverage for an individual, in the individual market, if the person fails to make required copayments to the insurer.

This bill substantially amends the following sections of the Florida Statutes: 627.410, 627.411, 627.6425, 627.6475, 627.6515, 627.667, 627.6692, 627.6699, 627.911, 627.9175, 627.9403, 627.9408, 641.31, and 641.3111. This bill also creates one undesignated section of law.

II. Present Situation:

The Florida Health Insurance Study (FHIS)

In 1998, the Legislature created the Florida Health Insurance Study (FHIS)[1] to be conducted by the University of Florida for the Agency for Health Care Administration (AHCA). This multi-year project was intended to provide a detailed understanding of the exceedingly complex issues of uninsurance and health insurance coverage. The primary focus was a large-scale telephone survey of Floridians under the age of 65. The research team surveyed over 14,000 households representing more than 37,000 individuals.

According to the FHIS report released in March 2000, 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).[2] The uninsured are heavily concentrated in certain regions of the state, where they are putting significant stress on "safety net" health care providers.

The FHIS report indicated that 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 ($35,300 annual income for a family of four).

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.

Regarding employment status, the FHIS report found that 50 percent of the uninsured work full or part-time and 62 percent of Floridians gain access to health insurance through their employer. A majority of the working uninsured (89 percent) say they do not have health insurance because their employer does not offer it, or they are not eligible, or they cannot afford it. Employers with one to nine employees have the highest rate of uninsureds (24.6 percent), compared to companies with 100 or more employees (4.78 percent).

As far as ethnicity is concerned, the report stated that Hispanics make up nearly one-fourth (492,154) of Florida's uninsured population. The rate of non-insurance for Hispanics (28.59 percent) is more than twice the rate of white non-Hispanics (13.2 percent) and almost 50 percent greater than the rate of African Americans (19.6 percent).

[1] http://www.fdhc.state.fl.us/Publications/FHIS/index.html
[2] Note that the 2000 Census estimated the total number of uninsured Floridians to be 19 percent of the population (U.S. Department of Labor).

The rates of uninsurance vary widely from region to region across the state. The three areas with the highest *number* of uninsured residents are District 1 with 128,000 uninsured (Bay, Escambia, Gadsden, Leon, Okaloosa and Santa Rosa), District 16 with 178,000 uninsured (Broward) and District 17 with 450,000 uninsured (Dade). The three areas with the highest *percentage rate* of uninsured residents are District 13 with 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 Kaiser 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.

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 AHCA. 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, which is now on appeal.

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.

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.

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 (and "Limited Benefit" Policies and Contracts)

The Employee Health Care Access Act in s. 627.6699, F.S., requires insurers in the small group market to guarantee the issuance 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 two 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 current law 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.

For health insurance policies, the law does not specify maximum deductibles, maximum copayments, or minimum annual or lifetime benefits. Therefore, health insurance policies sold to small or large groups may impose limits for such benefits (unless a specific mandatory benefit states that a deductible may not apply). For example, according to the Department, health insurance policy forms have been approved that limit annual benefits to $5,000 and $10,000. One statutory restriction is for preferred provider contracts, for which the law specifies the

maximum *difference* between the deductibles and coinsurance amounts for preferred providers and the deductibles and co-payments for non-preferred providers (ss. 627.6471 and 627.662(8), F.S.).

However, for HMO contracts, the laws and rules adopted by the Department restrict an HMO's authority to limit deductibles and co-payments. The law states that HMO contracts must provide "comprehensive" health care services (s. 641.19 (12), F.S.) The Department rules more specifically limit the maximum co-payments that an HMO may impose to $15 per visit and also limit the annual maximum out-of-pocket costs for an HMO subscriber to $1500 for single coverage and $3000 for family coverage. (OI Rule 4-191.035, F.A.C.) However, the rules do not specify a minimum annual or lifetime maximum benefit that an HMO contract must contain. According to representatives for the Department, no HMO has yet made a filing to force the department to make a determination as to whether a proposed annual or lifetime maximum would be too low to be considered "comprehensive."

The basic plan currently has a lifetime benefit limit of $500,000 and a $500 annual deductible for individuals and $1,000 annual deductible for a family. The maximum out-of-pocket expense limit is $4,800 for an individual and $9,600 for a family. The standard plan has a lifetime benefit limit of $1 million and deductibles in the range of $250 - $1,000 for an individual and $750 - $3,000 for a family. The maximum out-of-pocket expense limit for the standard plan is $2,000 for an individual and $4,000 for a family.

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.

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 prohibits 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, which must be one of three types: (1) a cash refund, (2) a shortened benefit period, or (3) a smaller dollar indemnity amount.

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 ten 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.

Renewal/Nonrenewal of Individual Health Insurance Coverage

Section 627.6425, F.S., governs renewability of individual health insurance coverage. This section provides that individual health insurance coverage to an individual must renew or continue in force at the option of the individual except under specified circumstances. An insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based on one or more of the following circumstances:

- The individual has failed to pay premiums or the insurer has not received timely premiums.
- The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- The insurer is ceasing to offer coverage in the individual market.

- In the case of an insurer that offers coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area.
- In the case of a health insurance coverage that is made available in the individual market only through one or more bonafide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases.

III. Effect of Proposed Changes:

Section 1. Creates an unnumbered section of law that authorizes the issuance of *health flex plans.*

Subsection (1) provides Legislative intent for health flex plans, with an emphasis on:

- Affordability and availability of health care coverage for low-income Florida residents unable to obtain such coverage;
- Encouraging entities which provide health insurance to develop alternative approaches to traditional health insurance;
- Providing basic and preventative health care services; and
- Coordinating with existing local service programs.

Subsection (2) provides definitions for the terms: "agency," "department," "enrollee," "health care coverage," "health flex plan," and "health flex plan entity." The definition of a "health flex plan entity" which may be approved to issue health flex plans, includes 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 a plan and is responsible for administering the plan and paying all claims.

Subsection (3) creates the pilot program in which the Agency for Health Care Administration (AHCA) and the Department of Insurance (Department) are directed to each approve or disapprove health flex plans that provide health care coverage for eligible participants residing in the *three areas of the state having the highest number of uninsured persons*, as determined by the Florida Health Insurance Study (FHIS). The three areas in the FHIS are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa counties), District 16 (Broward county), and District 17 (Dade county). In addition, Indian River County would be included. The health flex plans are authorized to:

- limit or exclude mandated benefits;
- cap the total amount of claims paid per year per enrollee,
- limit the number of enrollees, or
- take any combination of the above actions.

The bill specifies that AHCA must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Department of Insurance must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

- Provide benefits that are unreasonable in relation to the premium charged, contain provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate that the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

Both ACHA and the Department are given authority to adopt rules as needed to implement this section.

Subsection (4) provides that plans approved under this section are *not* subject to the licensing requirements of the Florida Insurance Code or chapter 641, F.S., relating to health maintenance organizations (HMOs), unless expressly made applicable. The subsection provides that for the purposes of prohibiting unfair trade practices, plans are considered insurance subject to the applicable provisions of part IX of chapter 626 (Unfair Trade Practices), F.S., except as otherwise provided in this section.

(Note: Insurance companies and self-insurance plans are governed by chapters 624 through 632, 634, 635, 638, 642, 648 and 651 ("Florida Insurance Code") of the Florida Statutes. HMOs are governed by parts I and III of ch. 641 of the Florida Statutes and are exempt from the Florida Insurance Code, except for provisions specifically made applicable to HMOs. Insurance companies must be licensed by the Department to do business in Florida. Individual employer self-insurance plans are not licensed by the Department.)

Subsection (5) provides eligibility criteria. Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

- are 64 years of age or younger;
- have a family income equal to or less than 200 percent of the federal poverty level ($35,300 annual income for a family of four);
- are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or other public health care program, such as Kidcare, and have not been covered at any time during the past 6 months; and
- have applied for health care coverage through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

Subsection (6) provides requirements for record keeping. Every plan must maintain enrollment data and reasonable records of its loss, expense, and claims experience and must make such records reasonably available to enable the Department to monitor and determine the financial viability of the plan, as necessary. Provider networks and total enrollment by area must be reported to AHCA biannually so that the agency can monitor access to care.

Subsection (7) provides notice requirements. The denial, nonrenewal or cancellation of coverage must be accompanied by specific reasons for such action. The notice of nonrenewal or cancellation must be given at least 45 days in advance, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. It provides that if the plan fails to give the required notice, the coverage must remain in effect until notice is appropriately given.

Subsection (8) specifies that the coverage of a plan is not an entitlement and that no cause of action shall arise against the state, a local governmental entity, or any other political subdivision of this state, or the agency, for failure to make coverage available to eligible persons under this section.

Subsection (9) provides that AHCA and the Department must evaluate the pilot program and its effect on the entities that seek approval as health flex plans, as well as the number of enrollees, the scope of the coverage offered, and an assessment of the plans and their potential applicability in other settings by January 1, 2004, and jointly submit a report to the Governor, President of the Senate and Speaker of the House of Representatives.

Subsection (10) specifies that this section expires on July 1, 2004.

Section 2. Amends s. 627.410, F.S., related to filing and approval of forms.

Individual coverage under out-of-state group policies - Subsection (1) is amended to provide an exception to the current provision that group certificates need only be filed with the Department of Insurance 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.

Rate filing exemption for large group policies - 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.

Filing and use of certain individual health insurance rate filings - Subsection (6) revises the procedures for filing and approval of individual health insurance rates. *Currently*, health insurance rate filings are subject to the same procedures as policy form filings in subsection (2), which requires rates to be filed with the Department 30 days prior to use. The Department must approve or disapprove the filing within this 30-day period, or within a 45-day period if extended by the Department, or the filing is deemed approved. If the filing is disapproved, this triggers an insurer's rights under the Administrative Procedure Act to request a hearing, but this can effectively prohibit the insurer from implementing the rate change for many months. Therefore, this procedure is often referred to as a "prior approval" system.

The bill establishes new procedures for *individual* health insurance policies, excepting Medicare supplement policies, providing that the current procedures would not apply to rate filings that comply with certain criteria. By meeting this criteria, the insurer may "begin providing required notice to policyholders and charging corresponding adjusted rates in accordance with

s. 627.6043, upon filing." This would allow the insurer to begin sending the 45-day notice of the rate change to existing policyholders, as required by s. 627.6043, F.S., and allow the rate change to be implemented for such policyholders 45 days after the notice is provided. However, the insurer would be allowed to implement the rate change for new policyholders immediately upon filing with the Department.

In order to use the new rate filing procedure, the insurer must certify that it has met the following criteria:

- The insurer must have complied with annual rate filing requirements then in effect pursuant to subsection (7) since October 1, 2002, or for the previous 2 years, whichever is less and must have filed and implemented actuarially justifiable rate adjustments at least annually during this period;
- The insurer must have pooled experience (combined for rating purposes) all policy forms providing similar benefits as required by s. 627.410(6)(e)3.; and
- Rates for the policy form are anticipated to meet a minimum loss ratio of 65 percent over the expected life of the form (meaning that at least 65 percent of the premium must be paid out in benefits).

Meeting the above criteria allows the rate to be used without the Department's approval, but does not prohibit the Department from disapproving the rate. The Department may require the insurer to furnish additional information to demonstrate compliance, and if the Department finds that the rates are not reasonable in relation to premiums charged, under the bill's standards, the Department may order "appropriate corrective action." For example, the Department could order the insurer to change its rate, which would be subject to notice and hearing requirements of the Administrative Procedure Act (ch. 120, F.S.), but during the pendency of the rate dispute the insurer would be allowed to continue using the filed rate. But, if the Department is ultimately successful, it is not clear if the "appropriate corrective action" ordered by the Department could include a refund of that portion of the rate found to be excessive.

Policy forms with fewer than 1,000 policyholders - 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, F.S., relating to grounds for disapproval of health insurance forms and rates.

Standard for disapproval of health rate filings - The bill revises the grounds for which health insurance rate filings may be disapproved (although the law refers to disapproval of the form, rather than the rate). The current standard is that a health insurance form shall be disapproved if it "provides benefits which are unreasonable in relation to the premium charged." The standard is revised by the bill to be applied based on the original filed and approved loss ratio for the form and rules adopted by the Department under s. 627.410(6)(b), F.S.

The bill deletes the provision that requires the Department to disapprove health insurance rates "which result in premium escalations that are not viable for the policyholder market." In place of this general standard, the bill establishes specific criteria for rate disapproval. A rate that is actuarially justified would be disapproved in the following situations (which are generally within the control of the insurer), as follows:

1. The Department would disapprove the rate increase if it includes a reduction by the insurer of its loss ratio (the portion of the premium used to pay claims) that affects the rate by more than 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 due to the loss ratio reduction for existing insureds that is equal to the greater of 50 percent of medical trend or 10 percent. 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 three 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 s. 627.6475, F.S., related to the individual reinsurance pool.

Individual reinsurance pool - Currently, Florida law conforms to the federal HIPAA law that requires health insurers and HMOs to issue coverage to persons who are eligible for guaranteed-issuance of coverage. The Florida law allows an insurer to participate in a reinsurance pool for reinsuring HIPAA-eligible persons perceived by the insurer to be high-risk. A carrier may choose to be a reinsuring carrier and participate in the reinsurance pool, or be a risk-assuming carrier that does not participate. The pool is funded by reinsurance premiums paid by the reinsuring carrier, backed by assessments against other reinsuring carriers and, if necessary, risk-assuming carriers.

There are currently twelve carriers who have elected to be reinsuring carriers, but at this time none of these carriers have reinsurance with the pool for any covered lives. It is generally believed that certain requirements of the current law make the pool unattractive, such as: (1) The law requires that a carrier decide within 60 days after the commencement of coverage whether to reinsure an individual. (2) The carrier must pay a reinsurance premium that is five times the rate established by the board, which is the rate that is required to be set at levels that reasonably approximate the premium charged to eligible individuals for health insurance. (3) If an individual is reinsured, the carrier remains responsible for paying, each year, the first $5,000 in claims, 10 percent of the next $50,000 in claims, and 5 percent of the next $100,000.

The bill makes changes that give the reinsurance board much greater flexibility in designing the program and thereby make it a more viable option to insurers. (1) A carrier would have 90 days, rather than 60 days, after the commencement of coverage to elect to reinsure an individual. (2) The board of the reinsurance program would establish the reinsurance premium as part of the plan of operation approved by the Department. The current requirement would be deleted that the reinsurance premium be five times the base rate established by the board. (3) The board would also establish the deductible levels that could be selected by an insurer (indicating more than one option).

Section 5. Amends s. 627.6515, F.S. related to out-of-state groups.

Individual coverage under out-of-state group policies - 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 6. Amends s. 627.667, F.S., related to extension of benefits.

Extension of benefits - The current law requires group health insurers to provide an extension of benefits that continues the policy benefits for treatment of an accident or illness, for an insured that has a total disability, if the group policy is discontinued. The extension is required regardless of whether the group policyholder secures replacement coverage. In the case of maternity expense, the extension of benefits must be provided for a pregnancy which commenced while the policy was in effect, for the period of the pregnancy and not based on total disability. Specific provisions also apply to certain dental procedures.

The current law provides that this section also applies to Florida residents who are covered under certificates issued under an out-of-state group policy, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits. The bill strikes this exception, so that such Florida certificate holders would have the same extension of benefits rights as persons covered under group policies issued in Florida.

Section 7. Amends s. 627.6692, F.S., the Florida Health Insurance Coverage Continuation Act.

Sixty-three days to elect continuation of group coverage - The Florida Health Insurance Coverage Continuation Act ("Act") enables employees of small employers with fewer than 20 employees to continue their group health coverage for 18 months after it would otherwise terminate. This law is intended to cover those employees and dependents who are not protected by the federal COBRA law which applies to employers with 20 or more employees.

The bill increases from 30 days to 63 days, the time within which an employee or other qualified beneficiary may elect to continue their prior group coverage. As under current law, this must be done in writing to the insurance carrier and requires payment of the initial premium. This 63-day period is consistent with the 63-day period within which a HIPAA-eligible individual may obtain guarantee-issue coverage after his or her group coverage terminates.

Section 8. Amends s. 627.6699, F.S., the *Employee Health Care Access Act*, to make the following changes:

1. Renames the "limited" benefit policy the "flexible" benefit policy, which would be "a policy or contract that provides coverage for each person insured under the policy and that fulfills a reasonable need by providing more affordable health insurance." The bill deletes from the current definition of limited benefit policy reference to a policy that provides coverage for a specific disease(s), accident, or limited market. Each small employer carrier would still be required to offer to any employer the standard and basic benefit plans. In addition, the small employer carrier would be authorized to offer a flexible benefit policy. A flexible benefit policy may be offered only to a small employer that is not covered by any health insurance and has not been covered during the past 6 months.

2. As under current law, a law requiring coverage for a specific health care service or benefit or requiring reimbursement of a specific category of health care practitioner does not apply to a standard, basic, or flexible benefit policy (currently, limited benefit policy) unless that law is made expressly applicable to such policies. However, the bill provides that any covered disease or condition may be treated by any physician or dentist, without discrimination, licensed or certified to treat the disease or condition.

3. Provides that any law restricting or limiting deductibles, coinsurance, copayments, and annual or lifetime maximum benefits would not apply to any health plan policy offered to a small employer, unless such law is made expressly applicable to such policy or contract. This would primarily affect HMO contracts, for which current Department rules limit copayments and out-of-pocket expenses. For health insurance policies, no such restrictions currently apply, except for restrictions on the maximum difference between deductibles and coinsurance provisions for preferred providers and non-preferred providers, as provided in s. 627.6471, F.S.

4. Allows, for rating purposes, the experience of small employer groups of 1 employee to be separated from the small employer groups of 2 to 50 employees; however, the rate charged to one-life groups would be subject to a rate cap of 150 percent above the small

employer carrier's approved rate for groups of 2-50 employees (the rate cap would be 125 percent for policies in effect on July 1, 2002). 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.

5. Requires the appointment of a new health benefit plan committee under the act every 4 years beginning October 1, 2002, for the purpose of recommending modifications to the plans, which would be reported annually to the Senate President and Speaker of the House of Representatives. The committee would also be required to evaluate the implementation of this act and its impact.

6. Provides an exception to the current law that limits the guaranteed-issuance of small group coverage to one-life groups to an annual 31-day open enrollment period in August. The exception would be to require guarantee-issue any time during the year within 63 days after a one-life group loses coverage due to its carrier terminating all small group coverage in the state.

7. Provides flexibility to the board of the Small Employer Health Reinsurance Program, subject to Department approval, to establish reinsurance premiums, differing levels of deductibles, and corridors of reinsurance designed to coordinate with a carrier's existing reinsurance. The specific requirements for such features in the current law would be deleted. The bill also extends from 60 to 90 days the time within which a reinsuring carrier may elect to reinsure a covered employee, dependent, or group after coverage commences. Currently, there are seven reinsuring carriers and a total of 19 lives reinsured in the program. These changes are intended to make the program a more attractive and viable option to small employer carriers.

8. Requires the disclosure of the following statement on the application for coverage under a flexible benefit policy or contract: "The benefits provided by this health plan are limited and may not cover all of your medical needs. You should carefully review the benefits offered under this health plan."

9. Provides cross-reference for the form filing requirements applicable to HMO health plans for purposes of offerings to small employers.

Section 9. Amends s. 627.911, F.S., related to the scope of part XVII of chapter 627, F.S., related to insurer reporting. The bill adds health maintenance organizations to the scope of the part, to require that HMOS report to the Department the information as required by this part.

Section 10. Amends s. 627.9175, F.S., related to reports of information on health insurance. The bill revises the information that must be submitted by health insurers to the Department, to require specific market information, including premium, number of policies, and covered lives, broken down by market segment, and other information necessary for analyzing trends in enrollment, premiums and claim costs. The Department would be authorized to adopt rules to administer this section including rules governing compliance and implementing electronic filing. The current requirements for health insurers to report information regarding cost-containment

measures and the Department analysis of such reports is deleted. The Department would be required to publish annually a "consumer's guide."

Section 11. Amends s. 627.9403, F.S., related to the scope of the laws that apply to long-term care insurance. The bill provides that a limited benefit policy that provides coverage for care in a nursing home is exempt from the requirement for long-term care polices that such coverage be for at least 24 consecutive months.

Section 12. Amends s. 627.9408, F.S., related to Department rulemaking authority relative to long-term care policies. 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 regulation 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 13. Amends s. 641.31, F.S., related 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 14. Amends s. 641.3111, F.S., related to extension of benefits for HMO contracts. Current law requires group HMO contracts to provide for an extension of benefits after the termination of the contract, for any continuous loss which commenced while the contract was in force if the subscriber continues to be totally disabled. The bill deletes the additional condition that the extension of benefits may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member. The bill also provides that the extension is required regardless of whether the group contract holder or other entity secures replacement coverage and strikes a specific exception in this regard for maternity coverage.

Section 15. Amends s. 627.6425, F.S., to permit an insurer to refuse to nonrenew or discontinue health insurance coverage of an individual in the individual market if the person fails to make required copayments to the insurer. When the unpaid copayment exceeds $300, the insurer must allow the insured 90 days after the date of the procedure to pay the required copayment. The

declaration-of-benefits page of the contract must notify the insured of this provision in 10-point type.

Section 16. Provides an effective date of October 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

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:

None.

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 or in Indian River County 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 flexible 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 flexible benefit policy may have greater out-of-pocket costs for benefits that are not covered. These changes primarily affect HMO contracts which are subject to department rules that limit copayments and maximum out-of-pocket expenses.

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:

The Department of Insurance reports that this bill has no fiscal impact.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.