SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2264

SPONSOR: Banking and Insurance Committee and Senator Atwater

SUBJECT: Health Insurance

DATE: April 10, 2003 REVISED: _____ _____ _____ _____

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

I. Summary:

The bill revises the criteria for a policy issued to a group outside of Florida, but which covers Florida residents ("out-of-state group policy"), to be exempt from the requirements that apply to group health insurance policies issued in Florida related to mandatory benefits, pre-existing condition limitations, guaranteed renewability, and other requirements of part VII of ch. 627, F.S. The bill also revises the grounds for disapproval of rate filings for health insurance policies issued in Florida.

Currently, out-of-state group policies are exempt from most of the requirements that apply to group policies issued in Florida, if certain criteria are met. The bill adds new criteria that must be met for out-of-state group policies issued on or after October 1, 2003. The new requirements would prohibit the insurer from discriminating against members of the group based on health status related factors, and would require that the group coverage be guaranteed renewable. Various exemptions are provided from the new requirements, limited benefit policies and exemptions provided by rule of the Financial Services Commission based on a determination that members of the group are provided protection for rate escalations.

The bill revises the standard for disapproval of health insurance rate filings, to provide more specific criteria. The changes require that health insurance policies meet a minimum loss ratio of at least 65 percent, meaning that at least 65 percent of the premium dollar must be used to pay claims. The changes also specify certain rate increases that would be disapproved and limited to certain amounts, even though they are actuarially supportable, due to being based on certain actions that are generally within the control of the insurer.

Current law generally exempts out-of-state group polices from rate filing and approval requirements, which the bill does *not* change. The impact of the bill, however, would effectively

require insurers to make one of three choices, to either: 1) meet the new criteria for an exemption from Florida's group insurance requirements by not using any health-related factor in establishing rates or eligibility for coverage, or for eligibility in the group, 2) issue individual health insurance policies in Florida, subject to the amended rating law requirements, or 3) withdraw from the Florida market and cease issuing new coverage in the state.

This bill substantially amends the following sections of the Florida Statutes: 627.411 and 627.6515.

II. Present Situation:

Health Insurance Rate and Form Filing Requirements

Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance (now the Office of Insurance Regulation, or "OIR") pursuant to ss. 627.410 and 627.411, F.S.[1] Rates must be filed at least 30 days prior to use and the office 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 (groups of 50 or less), 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 OIR may disapprove rates that are excessive, inadequate, or unfairly discriminatory, which may be defined by rule of the office, in accordance with generally accepted actuarial practice as applied by HMOs. The OIR may also disapprove a rate if the rating methodology followed by the HMO is determined by the office to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. (s. 641.31(2), F.S.)

The Department of Insurance adopted rules that establish minimum loss ratio requirements for all types of health insurance policy forms. (ch. 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. The rule allows the inclusion of expenses that reduce claim costs, such as claim management expenses. 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

[1] Effective January 7, 2003, the programs and activities of the Department of Insurance and the Department of Banking and Finance were transferred to the newly created Department of Financial Services and the Financial Services Commission. The Office of Insurance Regulation and the Office of Financial Institutions and Securities Regulation were created within the Financial Services Commission. The Office of Insurance Regulation is "…responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, adjusters, issuance of certificates of authority…" (s. 20.121(3)(a)1., F.S.) However, the Florida Statutes have not yet been amended to make conforming changes. This session, CS/CS/SB 1712 makes changes to the Florida Statutes to conform to the 2002 act.

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.

In recent years, the former Department of Insurance has attempted to revise its health insurance rating rules, which had been the subject of legal challenges. One issue was the definition of "viable" as used in the current statute that allows the office to disapprove a premium increase that is "not viable for the policyholder market." The OIR is in the process of reviewing this rule.

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 office 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 office 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.

Requirements for Group Health Insurance Policies Issued in Florida

Insurers issuing group health insurance policies in Florida must comply with the requirements of part VII of ch. 627, F.S. This part contains most of the mandatory benefit and coverage requirements that must be provided by such policies. (Some mandatory benefit requirements are

in part I of chapter 627, F.S.) One of the requirements, in s. 627.65625, F.S., prohibits group health insurers from establishing rules for eligibility of an individual to enroll under the terms of a policy based on health-status-related factors. These factors include, but are not limited to: health status, medical condition, claims experience, and medical history. This section also prohibits an insurer from requiring an individual, as a condition of enrollment or continued enrollment, to pay a premium that is greater than the premium for a similarly situated individual enrolled under the policy, on the basis of a health-status-related factor.

Another requirement for group policies, in s. 627.6571, F.S., is that the policy must be guaranteed renewable, at the option of the policyholder, subject to certain exceptions.

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.) This effectively exempts out-of-state group policies from rate approval requirements, because ss. 627.410 and 627.411, F.S., described above, require policy forms to be filed for approval, and health insurance forms may be disapproved if the office (formerly, department) determines that the rates do not meet certain standards.

The law also provides an exemption for out-of-state group policies that meet certain criteria, from the requirements of part VII of ch. 627 that apply to group policies issued in Florida.(described above). To qualify for this exemption, the out-of-state-group policy must meet three criteria: 1) the policy must be issued to one of the types of groups listed in the statute; 2) the certificates of coverage issued to Florida residents must contain the statement, "The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida," and (3) the policy must provide certain benefits, but not all, that group health insurance policies in Florida must provide.

The first criteria regarding the type of group to which the policy is issued, includes all types of groups authorized in Florida, plus any type of association group. But, if the group is established "primarily for the purpose of providing insurance," the benefits must be "reasonable in relation to the premiums charged." This provides the office with some authority to determine whether rates are reasonable in order for the out-of-state group policy to be entitled to the exemption. But, the office asserts that 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 paper credentials as to some other purpose. The OIR reports 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.

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 OIR for informational purposes. The requirement that certain benefits must be provided in order

for the exemption to apply is subject to spotty enforcement, at best, due to the absence of a requirement to file policy forms with the office 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.[2] 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.)

For certain types of policies, Florida law fully regulates out-of-state group policies covering Florida residents. The Florida laws that apply to "small group" policies issued to employers with 1 to 50 employees apply to out-of-state associations covering a small employer in Florida. (s. 627.6699, F.S.) Also, certificates issued to Florida residents under an out-of-state group Medicare supplement policy are subject to state rating laws.(ss. 627.672 and 627.6745, F.S.) Similarly, for long-term care policies, 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.

Individual Health Insurance Market Share

According to information provided by the Department of Financial Services, 383,637 individual health insurance policies are currently issued in Florida. These are the so-called "true" individual health insurance policies issued in Florida, which are medically underwritten, meaning that the individual is determined by the insurer to be acceptable, based on their health status and medical history. Another 4,705 "HIPAA" policies have been issued in Florida on a guaranteed-issue basis to persons eligible for such coverage. All but 11,144 of the 383,637 policies are issued by 19 different insurers. However one insurer, Blue Cross Blue Shield of Florida dominates this market with 193,0435 policies. Also, most of these insurers are not issuing new coverage in the state, and are only renewing old business.

In comparison, 176,539 individual certificates are currently issued in Florida under out-of-state group policies. Another 836 certificates under out-of-state group policies are issued to HIPAA-eligible individuals. All but 1,560 of the 176,539 policies are written by 18 different insurers, some of which are the same insurers that have "true" individual health insurance policies in force in the state.

All of the individual coverage in Florida is a relatively small percentage of the total insured market in Florida. The vast majority of insured persons are covered under group policies issued to employers in the state.

[2]Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

III. Effect of Proposed Changes:

Section 1 (Rating Law Changes for Policies Issued in Florida)
The bill amends s. 627.411, F.S., to revise the grounds for disapproval of health insurance policies issued in Florida, based on certain rating practices.

The bill requires a minimum loss ratio of 65 percent for all health insurance coverage (as described in s. 627.6561.(5)(a)2., F.S.). This is the minimum loss ratio standard for incurred claims to earned premiums which, in general, means that at least 65 percent of the premium dollar must be used for claims payments, and no more than 35 percent may be used for expenses and profit. The bill provides additional details of what must be included in calculating incurred claims and what may not be included, including costs that a company may include at its discretion.

The bill also deletes the general standard that requires the department[3] 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 (nevertheless) be disapproved in the following situations, which are generally situations 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 for existing insureds that is equal to the greater of 150 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 following 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 revises the ground for disapproval of a health insurance policy that applies rating practices that result in unfair discrimination, to specifically refer to the prohibited practices in s. 626.9541(1)(g)2., F.S. This prohibits any unfair discrimination between individuals of the

[3] The current statute and this analysis refer to the "department" meaning the former Department of Insurance. This bill does not change this reference, but CS/CS/SB 1712 would change the reference to "office" defined as Office of Insurance Regulation. See fn. 1.

same actuarially supportable class and essentially the same hazard, in the amount of premium, fees, or rates charged for any policy or contract of health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner.

Section 2 (Revised Exemption for Out-of-State Group Policies)
The bill amends s. 627.6515, F.S., relating to the regulation of group policies issued outside the state of Florida under which a resident of Florida is provided coverage. The bill would revise the exemption for such policies from the requirements that apply to group policies issued in Florida. Note that the exemption provided in this section is not an exemption from policy form and rate approval requirements which is provided in s. 627.610, F.S. The exemption in s. 627.6515, F.S., is an exemption from benefit requirements, pre-existing condition limitations, anti-discrimination prohibitions, and other requirements in part VII of ch. 627, F.S.

The bill adds to the current criteria that must be met for the exemption, in new paragraphs (d) and (e) of subsection (1). The first criteria , in paragraph (d), is applicable only to policies or contracts issued on or after October 1, 2003. It would require that the policy comply with the antidiscrimination provisions set forth in s. 627.65625, F.S., regarding rating and eligibility for enrollment and for any benefit under the policy. This prohibits group health insurers from establishing rules for eligibility of an individual to enroll under the terms of a policy based on health-status-related factors. It further prohibits an insurer from requiring an individual, as a condition of enrollment or continued enrollment, to pay a premium that is greater than the premium for a similarly situated individual enrolled under the policy, on the basis of a health-status-related factor. New paragraph (d) would also require that the policy comply with s. 627.6571, F.S., which requires group policies to be guaranteed renewable. However, the criteria for paragraph (d) would not apply to policies issued to provide coverage to groups of persons all of whom are in the same or functionally related licensed professions, and providing coverage only to such licensed professions.

The bill also adds criteria in new paragraph (e) that must be met for the exemption. It would require that the policy *not* be issued to a group that directly or indirectly uses any health status related factor in determining eligibility for initial or continued membership in the group or continued eligibility to participate in any aspect of the group insurance program. However, this criteria would not apply to an employer group. This requirement would also not apply to policies or certificate issued prior to October 1, 2003.

The bill provides a further exemption from the new criteria in paragraphs (d) and (e), for certain types of limited policies, such as accidental death, accident-only, vision-only, dental-only, hospital indemnity, cancer, specified disease, Medicare Supplement, long-term care, disability income insurance, and similar supplemental plans provided under a separate policy (etc.).

Further exemptions from the new criteria are authorized to be adopted by rule, by the Financial Services Commission (the Governor and Cabinet sitting as the rulemaking body for the OIR). Such rules must establish standards for determining that the members of the group policy are provided protection from rate escalations from the segregation of risks and that members are provided protection by an individual or board that is not owned or controlled by the carrier or affiliate of the carrier and acts in a fiduciary capacity for the protection of its members.

A further exemption from the new criteria is provided. The OIR must provide, upon request, a 90-day exemption from the October 1, 2003, effective date of the new criteria in paragraphs (d) and (e), to any insurer having an approved filing for individual business by October 1, 2003, and certifying that each individual issued a policy or certificate after October 1, 2003, will be offered the opportunity to switch his or her policy to the new form at the end of the exemption period.

The bill also revises the current criteria in paragraph (a) which requires that the policy be issued to a specified type of group. The bill would limit the current reference to a franchise health policy when the composition of the group is substantially in compliance with s. 627.663, F.S., to such policies that are issued prior to January 1, 2003.

If the group policy does not comply with these new requirements, then, the policy is not eligible for the exemption from the requirements of part VII of ch. 627, F.S., that apply to group policies issued in Florida. The Financial Services Commission is required to adopt rules necessary to administer the provisions of this section.

Section 3 provides that this act shall take effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurers marketing coverage to Florida residents through out-of-state group policies face a choice under this bill. One choice is to meet the new criteria for enjoying an exemption from Florida's group insurance requirements by not using any health-related factor in establishing rates or eligibility for coverage under the policy, or for eligibility in the group itself. A second choice is to issue individual health insurance policies in Florida, rather than marketing through an out-of-state group, and be subject to the laws that apply to individual health insurance policies, including the rating law requirements that are amended by this bill. The amended provisions provide more specific standards than under

current law and arguably provide insurers with greater certainty as to approval and disapproval of a rate filing. A third choice for an insurer is to withdraw from the Florida market and cease issuing new coverage in the state. (But, note the exemptions from the new criteria that the bill authorizes, for which current market practices could continue.) The choice any given insurer will elect is unknown.

Florida residents who obtain coverage under an out-of-state group policy issued after October 1, 2003, will be afforded the protection of the laws that prohibit group insurers from discriminating on the basis of health status. The insurer could not require an individual to pay a premium that is greater than the premium for a similarly situated individual enrolled under the policy on the basis of health-status-related factor. If an insurer, instead, elects to offer individual health insurance policies in this state, Florida residents will be protected against "death spiral" rating practices that leave persons with bad health no other coverage option. It is likely that the initial premium for such polices will be higher, but future rate increase would be smaller. However, to the extent that some insurers elect to withdraw from the market, there may be fewer insurers from whom individual coverage is available.

Florida residents who are currently covered under out-of-state group policies are generally not affected by this bill, since the new requirements apply only to policies or contracts issued on or after October 1, 2003.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.