HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 999 Health Insurance Policies (Out-of-State Group Policies)
SPONSOR(S): Negron
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 2264(S)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Subcommittee on Health Access & Financing	7 Y, 0 N	Cooper	Schulte
2) Insurance			
3) Commerce&Local Affairs Appropriations			
4) Appropriations			
5)			

SUMMARY ANALYSIS

Insurers who issue health insurance policies in Florida are required to file their forms and rates for approval with the Office of Insurance Regulation. Health insurance rates may be disapproved if the policy provides benefits that are unreasonable in relation to the premium charged; contain provisions that are unfair, inequitable, contrary to the public policy, or encourage misrepresentation; or apply rating practices that result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices.

Insurers who issue policies to groups or associations outside of Florida, but which are sold and marketed to individuals in Florida, are generally exempt from Florida's rate and form filing and approval requirements.

The bill revises the criteria for out-of-state group insurers to be exempt from regulation as group insurers under the Florida Insurance Code and provides additional regulation of those insurers.

There is no fiscal impact on the Office of Insurance Regulation. Premiums for some out-of-state group policyholders may increase initially and then stabilize generally.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a "no" above, please explain:

Certain entities currently not subject to regulation by the Office of Insurance Regulation would be under this proposal.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Insurance Rate and Form Filing Requirements

Insurers who issue health insurance policies in Florida are required to file their forms and rates for approval with the Office of Insurance Regulation (office) pursuant to ss. 627.410 and 627.411, F.S.[1] Rates must be filed at least 30 days prior to use and OIR 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 health maintenance organization (HMO) contracts.

The primary grounds for disapproval for health insurance rates are if the policy "provides benefits which are unreasonable in relation to the premium charged, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices 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.).

The office has adopted rules that establish minimum loss ratio requirements for all types of health insurance policy forms (chapter 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. Recently, the rule was revised to allow 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 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

[1] Effective January 7, 2003, the programs and activities of the Department of Banking and Finance and the Department of Insurance were transferred to the newly created Department of Financial Services and the Financial Services Commission. The Office of Financial Institutions and Securities Regulation and the Office of Insurance 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.)

percent for group policies with 51-500 certificates; and 75 percent for group policies with greater than 500 certificates.

In recent years, the office (as the 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 office is in the process of reviewing this rule and has proposed language in Cs/SB 2264 to delete the use of the term "viable," replacing it with more detail as to what is actually envisioned by the concept.

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 office (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 who 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.

Section 627.65625, F.S., prohibits insurers who offer group health insurance policies from establishing rules for eligibility of an individual to enroll under the terms of a policy based on certain health-status related factors. These factors include, but are not limited to: health status, medical condition, claims experience, medical history. The section also prohibits an insurer from requiring an individual, as a condition of enrollment or continued enrollment to pay a premium or contribution that is greater than such premium for a similarly situated individual enrolled under the policy on the basis of the health-status related factor. Except as otherwise provided in s. 627.6571, F.S., an insurer that issues group coverage is also required to renew or continue to renew such coverage at the option of the policyholder.

Limited Regulation of Out-of-State Group Policies

Insurers who 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 office "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 office with some authority to determine whether rates are reasonable, according to the

office, 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 office reports 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, as found in "The Employee Health Care Access Act," (s. 627.6699, F.S.) 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 office 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 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 Health Insurance Portability and Accountability Act (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.).

According to the Office of Insurance Regulation, as of January 2002, there were over 175,000 Florida residents who were covered by out-of-state group health insurance policies.

Effect of Proposed Changes:

The bill revises the criteria for out-of-state group insurers to be exempt from regulation as group insurers under the Florida Insurance Code and provides additional regulation of some aspects of their operation. It amends subsection (2) of s. 627.6515, F.S., in an attempt to eliminate abuses noted by the office in which some out-of-state group insurers obtain "approval" of their out-of-state group policy forms in other states/jurisdictions that have no specific standards for review of the policies and "review and approve" the policies on a "voluntary" basis. It also clarifies that where provisions of other statutes in part VII of chapter 627, F.S., specifically indicate they apply to out-of-state group health insurance, such provisions shall apply to those policies, not withstanding that those policies are otherwise exempt from part VII pursuant to s. 627.6515(2), F.S.

HB 999 also amends subsection (2) of s. 627.6515, F.S., which defines the types of groups to which out-of-state group health insurance policies may be issued. According to the office, these amendments are intended to tighten up provisions that the office believes have been used to issue out-of-state group policies to individuals under the guise of an entity that is truly not a group.

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

The bill creates a new subsection (9) to address several issues. Among the additions is a list of provisions applicable to out-of-state group health insurance, designed to eliminate the premium "death spirals" previously discussed. Another paragraph provides a list of types of out-of-state group health insurance policies that are not subject to new subsection (9), because, according to the office, they have not been noted by the office to be the source of complaints.

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The bill also creates a new subsections (10) and (11) in s. 627.6515, F.S., to provide the Department of Insurance (which in this case would be the Financial Services Commission) with rulemaking authority to allow the department to excuse insurers from complying with s. 627.6515(4) and (5), F.S., (obtaining approval of the policy in the state of issue) where the department determines that such approval cannot practicably be obtained and is not needed for consumer protection. Finally, the bill creates new subsection (12) clarifying which parts of s. 627.6515, F.S., apply to exempt out-of-state group policies, and which apply to non-exempt out-of-state group health insurance policies.

C. SECTION DIRECTORY:

Section 1: Amends s. 627.6515, F.S., relating to out-of-state groups.

Section 2: Provides the act takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill provides out-of-state group policy and certificate holders with consumer protections similar to those provided by group and individual insurers regulated by the office. Florida residents covered under out-of-state group policies are afforded greater protection against "death spiral" rating practices since the carrier is prohibited from discriminating against an individual due to health-status related factors. The insurer could not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled under the policy on the basis of health-status related factors. It is likely that the initial premium for such polices will be higher, but future rate increases will be smaller.

Those insurers who market individual coverage certificates in Florida under out-of-state group policies are required to comply with Florida laws prohibiting discrimination against individuals based on health status and guaranteed renewability of coverage to maintain their exemption from group regulation

under Florida insurance laws. Those insurers who comply with these additional requirements to maintain their exemption from group regulation in Florida may incur additional regulatory costs and lose some of their competitive advantage over insurers who are subject to Florida laws regarding rates and filings. Some representatives of insurers who market out-of-state group policies claim that many insurers will choose not to sell coverage in Florida if they are subjected to these Florida laws. As an alternative to meeting the new out-of state group requirements, a carrier could decide to issue individual policies and be subject to the individual rate regulation in Florida.

This legislation is intended to provide a more competitive market for individual health insurance coverage in Florida. Florida's insurers would no longer lose "healthy insureds" to an out-of-state group that is not required to comply with the adequate rates and reasonable benefits that are characteristic of individual coverage issued in Florida.

D. FISCAL COMMENTS:

The Office of Insurance Regulation has indicated that the additional filing workload for the office will be addressed with current resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

Not applicable.

B. RULE-MAKING AUTHORITY:

The Financial Services Commission is authorized to draft rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 9, 2003 the Subcommittee on Health Access and Financing passed a strike-everything amendment, which modifies the bill's intent and effect in several ways.

- In subsection (2) of s. 627.6515, F.S., it adds an additional factor in considering whether an out-of-state group is excluded from the regulatory requirements of part VII. It excludes a group if the insurer's state of domicile has approved the policy and the policy is available for sale in the insurer's state of domicile. The effect of this provision is to continue to cede rate authority to other states for individual coverage by companies marketing through group mechanisms.

- Another feature of this amendment is that it strengthens disclosure requirements regarding out-of-state group policies. Currently the certificate must contain a statement that the benefits of the policy providing coverage are governed primarily by the law of the state other than Florida. This statement only applies after an insured has applied, been accepted, and is presented a certificate (policy). The amendment requires applications to contain, in larger print than the current disclosure, a disclaimer that provides because the policy is governed by the laws of another state, all of the rating laws applicable to policies filed in Florida do not apply to the coverage. Consequently, as the

disclaimer points out, this may result in increases at renewal that would not be permissible under a Florida-approved policy. It also cautions that any purchase of individual health insurance should be considered carefully as future medical conditions may make it impossible to qualify for another individual health policy. This disclosure is only required for group certificates that require individual underwriting to determine coverage eligibility for an individual or premium rates to be charged an individual.

- The amendment contains two provisions that address certain rating practices of out-of-state groups. It adds a new subsection (9) to 627.6515, F.S., to prohibit renewal premium rating practices that are based exclusively upon a covered person's individual claims experience or a change in a covered person's health status.

- The second provision is new subsection (10). The intent and purpose is to require uniform maximum percentage rate increases for coverage in force for 3 years. The amendment's ultimate effect is unclear, because of the lack of specificity as to how any uniform maximum percentage increases are to be determined. It states that the maximum percentage that would be applied is calculated by comparing increases between substantially similar plans, but certain policies can be considered and potentially excluded, resulting in the possibility of various maximum percentage increases.

- Finally, the amendment adds a paragraph to s. 627.410(6)(b), F.S., relating to health insurance form filings and approvals. This amends the exclusion for out-of-state groups to allow an exemption if the insurer, in addition to meeting the other requirements of s. 627.6515, F.S., files its rates with the Office of Insurance Regulation for information purposes only, and the filing is accompanied by an actuarial certification that the loss ratios for the certificates meet or exceed the standards in s. 627.411(2). Under current law (to which this cross-reference refers) the office, in determining whether the benefits are reasonable in relation to the premium charged, shall, in accordance with reasonable actuarial techniques, consider: (1) past loss experience and prospective loss experience within and without this state; (2) allocation of expenses; (3) risk and contingency margins, along with justification of such margins; and (4) acquisition costs.