HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Subcommittee on Health Access & Financing	7 Y, 0 N	Cooper	Schulte
2) Insurance	15 Y, 0 N w/CS	Cooper	Schulte
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.

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 practices of 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. 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 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.

[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.)

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/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 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 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.

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

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

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 193,435 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.

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.

Section 1 amends s.627.410 (6)(b), F.S. relating to health insurance form filings and approvals. It 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). An exception is provided for policies for groups of persons all of whom are in the same or functionally related licensed professions and for bona fide associations (characteristics of which are as defined in s. 627.6571(5), F.S.).

Section 2 amends subsection (2) of s. 627.6515, F.S., to add 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 master policy has met the filing requirements of the state of policy situs and is available for sale in the state of policy situs.

It is unclear whether this qualification provides any additional consumer protections or regulatory safeguards. The answer depends on the regulatory framework of the state where the policy has been approved or filed.

Also in subsection (2), paragraph (d) is added to strengthen 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.

Subsection (5) is amended to require certification from an actuary that the premium structure for policies complies with new subsections (9) and (10) of s.627.6515, F.S.

Subsection (9) is added 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. An exception is provided for policies for groups of persons all of whom are in the same or functionally related licensed professions.

The effect of subsection (9) will be to prevent "reunderwriting", also called "tier rating" after the various groupings or "tiers" of rates established for different people in a class. The provision addresses one aspect of the death spiral where an individual is singled out for premium increases due to his or her claim experience. It does not address other aspects of the death spiral which can occur based on durational rating or the periodic closing of blocks of business.

Also, a provision is added to specify that if an insurer has ever utilized the renewal premium adjustments prohibited in (9), then the insurer must file new renewal premium rates with the department for informational purposes only and must eliminate the effects of the prohibited adjustments on a revenue neutral basis.

Subsection (10) is created to require uniform maximum percentage rate increases for substantially similar policies for groups formed primarily for purposes other than providing insurance which have been in force for a period of 30 months. The Financial Services Commission is authorized to adopt rules to establish the meaning of the term "substantially similar benefits."

An exception from the subsection is provided for policies for groups of persons all of whom are in the same or functionally related licensed professions.

The bill also creates new subsection (11) to prohibit a person who voluntarily terminates group policy from being eligible for a policy by the same insurer to the same association for six months from termination unless the new policy is available to all other insureds under the existing policy without regard to health status.

Finally as to this section, a new subsection (12) is created stating that if the Office of Insurance Regulation determines on or after July 1, 2006, through public hearings, that pooling, as provided for in this section, has failed to adequately prohibit rating practices that disproportionately discriminate against individuals who have filed claims or developed medical conditions, out-of-state groups that individually underwrite are considered policies issued on an individual basis and must be regulated as such.

Section 1 amends s.627.410 (6)(b), F.S. relating to health insurance form filings and approvals. It 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). An exception is provided for policies for groups of persons all of whom are in the same or functionally related licensed professions and for bona fide associations (characteristics of which are as defined in s. 627.6571(5), F.S.).

C. SECTION DIRECTORY:

Section 1: Amends s. 627.410, F.S., relating to filing, approval of forms.

Section 2: Amends s. 627.6515, F.S., relating to out-of-state groups.
Section 3: 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:

Individuals who are currently affected by the most egregious cases of death spiral practices should benefit from the additional restrictions contained in this bill. For those individuals, premiums should not escalate as rapidly as would otherwise occur, resulting in continuation of health insurance coverage.

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:

A cross-reference to loss ratio standards contained in s. 627.410(6)(b), F.S., was added in the committee substitute (line 56). This reference appears to be in error as there are no loss-ratio standards provided in that subsection.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

House Bill 999, as originally filed, like the committee substitute, revised the criteria for out-of-state group insurers to be exempt from regulation as group insurers under the Florida Insurance Code and provided additional regulation of some aspects of their operation. It amended 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 clarified 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 amended 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 changes were 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.

The bill created a new subsection (9) of s. 627.6515, F.S., 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 created 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 created 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.

The major difference between the original bill as filed and the committee substitute is that the original bill attempted to regulate out-of-state groups in a manner much more similar to the regulation of individual policies, whereas the committee substitute takes a more limited approach and addresses some, but not all, the practices that often lead to "death spiral" situations. For instance, durational rating and closing blocks of business will still be allowed under the committee substitute.