# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 1238

SPONSOR: Banking and Insurance Committee and Senator Brown-Waite

SUBJECT: Insurance (Health Maintenance Organizations; Rate Changes)

DATE: March 5, 1999 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Deffenbaugh | Deffenbaugh | BI | Favorable/CS |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## I. Summary:

Currently, health maintenance organizations may change rates that are charged for an HMO contract immediately upon filing the rate change with the Department of Insurance, subject to disapproval by the department, based on a determination that the rate is excessive, inadequate, or unfairly discriminatory. Certain other prohibited rate standards also apply. Following receipt of notice of disapproval, the HMO may not use the rate. Also, any change in the rate requires at least 30 days' advance written notice to the subscriber.

The committee substitute applies to HMOs the same rate filing procedures that apply to health insurers. This would require HMOs to file rates at least *30 days in advance of use*. The department may approve or disapprove the rate during this 30-day period, or during an extended period of an additional 15 days if the department gives notice of the extension. If the department disapproves the rate during this period, the HMO may not use the rate but may pursue its administrative hearing rights if it challenges the department's findings. If, however, the department does not affirmatively approve or disapprove the rate during this 30 to 45 day time period, the rate is deemed approved.

This bill substantially amends section 641.31 of the Florida Statutes.

## II. Present Situation:

Currently, s. 641.31(3)(a), F.S., provides that health maintenance organizations (HMOs) may change rates that are charged for an HMO contract immediately upon filing the rate change with the Department of Insurance, subject to disapproval by the department. Following receipt of notice of disapproval or withdrawal of approval, the HMO may not use the rate. This procedure for rate changes is part of, and identical to, the procedures the HMO must follow for changes to its forms or contracts.

Any change in an HMO's rates requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the HMO to have the employer provide the required notice to the individual members of the group. [s. 641.31(3)(a), F.S.]

Subject to the above procedures, the department may disapprove rates charged by an HMO that are excessive, inadequate, or unfairly discriminatory. The department, in accordance with generally accepted actuarial practice as applied by HMOs, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets such requirements. [s. 641.31(2), F.S.]

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. Use of the rating methodology must be discontinued immediately upon disapproval unless the HMO seeks administrative relief. If a new rating methodology is filed with the department, the premiums determined by such newly filed rating methodology may apply prospectively only to new or renewal business written on or after the effective date of the responsive filing made by the HMO. [s. 641.31(3)(b)6., F.S.]

According to information provided by the department, HMOs will typically wait for department approval prior to implementing a rate change, even though the HMOs are legally entitled to use the rate immediately upon filing with the department. During 1998, only one HMO implemented a rate increase without department approval. This rate filing affected about 10,000 subscribers and the average premium before the rate increase was $1,925, and after the increase was $2,496, for an average increase of $571 per subscriber. The filing was disapproved by the department and the case is pending at the Division of Administrative Hearings. The department estimates that this HMO collected about $3 million in additional premiums in 1998 as a result of implementing this rate increase.

Further information provided by the department reflects all HMO rate increases as filed and as approved in 1998. According to this information 109 rate filings were made by 29 different HMOs. Of these 109 rate filings, 83 rate filings by 24 different HMOs were approved as filed. The other 26 rate filings by 13 different HMOs were ultimately approved at a rate lower than the rate filed by the HMO. The department estimates that had these 26 filed rate increases been implemented, the 13 HMOs, in total, would have collected in excess of $22 million more than the ultimately approved rate.

By way of comparison, rate (and form) changes for *health insurance* policies must be made not less than *30 days in advance of use*. At the expiration of this 30-day period, the rate is deemed approved unless prior to such time the rate has been affirmatively approved or disapproved by order of the department. The department may extend by not more than an additional 15 days the period within which it may affirmatively approve or disapprove the rate, by giving notice of the extension before expiration of the initial 30-day period. At the expiration of this maximum 45-day period, the rate is deemed approved in the absence of prior affirmative approval or disapproval. In general, the grounds for disapproval of a health insurance rate change are similar to the grounds

for disapproval of an HMO rate change, in that the rate may not be excessive, inadequate, or unfairly discriminatory. [ss. 627.410 and 627.411, F.S.]

## III. Effect of Proposed Changes:

**Section 1.** Amends s. 641.31, F.S., relating to health maintenance organization (HMO) contracts. The committee substitute applies to HMOs the same rate filing procedures that apply to health insurers. This would require HMOs to file rates at least *30 days in advance of use*, rather than being allowed to implement rates immediately upon filing with the department as currently authorized. The department may approve or disapprove the rate during this 30-day period, or during an extended period of an additional 15 days if the department gives notice of the extension. If the department disapproves the rate during this period, the HMO may not use the rate but may pursue its administrative hearing rights if it challenges the department's findings. If, however, the department does not affirmatively approve or disapprove the rate during this 30 to 45 day time period, the rate is deemed approved. [These requirements are provided in new paragraph (d) of s. 641.31(3), F.S.]

The bill does not change the current law that allows HMOs to amend contract forms and other forms immediately upon filing with the department, subject to disapproval by the department.

Necessary conforming changes are made in the bill to delete current rate approval provisions that are contained in the provisions of subsection (3) that relate to both the filing of forms and the filing of rates. The current provisions of s. 641.31(3)(b)6., F.S., that prohibit HMOs from using a rating methodology determined by the department to be "inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding," is transferred to subsection (2), which addresses HMO rate standards.

**Section 2.** The bill would take effect July 1, 1999, and apply to policies and contracts issued after that date.

## 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:

Requiring HMOs to file rates 30 days in advance of use makes it less likely that an HMO will implement a rate that the department determines is excessive. Consequently, subscribers would be less likely to pay a rate increase prior to department approval. But, as indicated by the HMO rate filings made in 1998, this may not be a significantly different effect than under current law, since only one HMO implemented a rate change without first obtaining department approval. On the other hand, the dollar impact could be significant, particularly to an individual subscriber, since the department estimates that in this one case, the average premium increased from $1,925 to $2,496, for an average increase of $571 per subscriber, and the HMO collected about $3 million in additional premiums in 1998 as a result of implementing this rate increase. (The filing was disapproved by the department and the case is pending at the Division of Administrative Hearings.)

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Amendments:

None.