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/CS/SB 1294

SPONSOR: Banking and Insurance Committee, Commerce and Economic Opportunities Committee, and Senator Holzendorf

SUBJECT: Employee Health Care Access Act

DATE: April 13, 1999 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Joseph	Maclure	CM	Favorable/CS
2.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
3.				
4.				
5.				

I. Summary:

The Committee Substitute for Committee Substitute for Senate Bill 1294 amends the "Employee Health Care Access Act," which entitles small employers with 1 to 50 employees, including sole proprietors and self-employed individuals, to have access to group health insurance coverage on a guaranteed-issue basis, with rates established without regard to the health status of the small employer or its employees. Currently the law limits the factors that an insurer or HMO ("small group carrier") may use in setting rates for small employers to age, gender, geographic location, tobacco usage, and family composition (size).

The bill makes the following changes:

- Eliminates the prohibition that rates not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers would be allowed 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 could be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors or due to dependents, but not to exceed 5 percent annually due to health status alone.

- Deletes the guaranty-issue requirements for employers with one employee, sole proprietors, and self-employed individuals and, instead, provides for an annual open enrollment period for such persons, for the month of August each year. Coverage would begin on October 1, unless the insurer and the policyholder agree to a different date. Any one-person small employer getting coverage must not be formed primarily for the purposes of buying health insurance and if an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group.

- Prohibits small group carriers from using "composite rating" for employers with fewer than 10 employees, which would prohibit averaging the impact of the rating factors for age and gender.

- Allows small group carriers to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group.

- Specifies certain family-size categories that a small group carriers may use.

- Clarifies the applicability of additional rate filing procedure and standards for insurers and HMOs, respectively.

The difficult question to answer, which may be the primary policy question, is whether eliminating one-person groups and allowing surcharges and credits based on health status will increase or decrease the total number of small employers and employees covered. It may be fair to say that in the short-term, initially lower rates for a small employer with a healthy risk profile is likely to increase the number of small employers willing and able to buy group coverage. However, over the long-run, the impact is likely to be neutral, or could even be negative, since employers and employees with greater than average costs may tend to be priced out of their coverage, while employers and employees with less than average claims costs may enjoy comparatively lower premiums that enable them to stay insured.

This bill substantially amends section 627.6699 of the Florida Statutes, 1988 Supplement.

II. Present Situation:

Florida's Employee Health Care Access Act

In 1992, the Employee Health Care Access Act (act) was enacted to require insurers in the small group market to guarantee the issue of coverage to any small employer that applies for coverage, regardless of the health condition of the employees. (s. 627.6699, F.S.) In 1993, the act was expanded to cover employers with one employee, including sole proprietors and self-employed individuals.

The act further requires that policies issued to small employers have premiums established on a "modified community rating" basis. Rates may be based only on age, gender, family composition, tobacco usage, and geographic location (s. 627.6699(3)(n), F.S.). Rates may not be based on the health status or claims experience of any individual or group, or any other factor.

An insurer or HMO that writes small group policies in Florida (a "small employer carrier") must elect to either be a risk-assuming carrier and assume all risk or be a reinsuring carrier and have the option of reinsuring identified high-risk individuals or groups with a reinsurance pool (s. 627.6699(9), F.S.). A reinsurance pool is established and funded through premiums and assessments on insurers, governed by the same board appointed to operate the Florida Small Employer Health Reinsurance Program. Risk-assuming carriers are not subject to losses in the reinsurance pool (s. 627.6699(11), F.S.).

Small group carriers are required to offer a "standard" and "basic" policy to small employers. The "standard" policy is generally intended to be comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy affordable. The statute specifies certain mandated benefits that apply to both the standard and basic policy, and a Health Benefit Plan Committee is created to develop and modify the standard and basic benefit plans. Small group carriers are required to offer all health benefit plans (not just the basic and standard plans) on a "guaranteed-issue basis," but additional or increased benefits may be added to the standard health benefit plan by rider and such riders may be medically underwritten.
The act defines the term "small employer" to mean, "in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met." (s. 627.6699(3)(v), F.S.)

The act defines the term "self-employed individual" to mean "an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years." (s. 627.6699(3)(u), F.S.)

Other aspects of the current law particularly affected by the bill are addressed in Effects of Proposed Changes, below.

Overview of Federal Law

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) was enacted to provide guaranteed availability and renewability of health insurance coverage for certain employees and individuals, and to increase portability through the limitation on preexisting condition exclusions.

Employer group plans are regulated, in part, by the federal government, under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code, and to the extent the plans purchase insurance, in part, by the states under state insurance laws and regulations. Policies sold in the individual market are regulated by the individual states.

HIPAA allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. HIPAA specifies that the federal provisions pertaining to health insurers in the individual market generally do not preempt state regulation of individual insurers. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual. HIPAA requires small employer carriers to guarantee the issuance of coverage to small employers with 2 to 50 employees.

III. Effect of Proposed Changes:

This bill amends s. 627.6699 F.S., 1998 Supp., the Employee Health Care Access Act, to make the following changes:

1. *Basing Rates on Health Factors* -- The bill eliminates the prohibition that rates for small employers not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers would be allowed 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 could be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors (or due to dependents), but not to exceed 5 percent annually due to health status alone. Any adjustments in rates for claims experience or health status may hot be charged to individual employees or dependents, but would, instead, be averaged over all of the employees of a particular small employer. For example, if the carrier's approved rate is $200 per month, the carrier would be permitted to charge from $170 to $230 per month, based on health status factors. (See Economic Impact for further analysis of this impact.)

   The bill requires small employer carriers to report information to the department on a semiannual basis, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the approved rate. If the aggregate actual premium exceeds the premium that would have been charged under the approved rate by more 5 percent, the carrier must use only *minus* adjustments (credits), beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate premium actually charged does not exceed the premium that would have been charged under the approved rate by more than 5 percent, the carrier may apply both plus and minus adjustments.

2. *Open Enrollment for One-Life Groups* -- The bill excludes from the law's guaranty-issue requirements employers with one employee, sole proprietors, and self-employed individuals. However, such individuals who are insured on July 1, 1999, would continue to be covered by the law's requirements that such polices be guaranteed-renewable. Also, for employers with one employee, sole proprietors, and self-employed individuals, small employer carriers would be required to provide an annual open enrollment period for the month of August each year. Coverage would begin on October 1, unless the insurer and the policyholder agree to a different date. Any such one-person small employer must not be formed primarily for the purposes of buying health insurance. If an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group.

   Since the federal HIPAA law definition of small employer covers 2 to 50 employees, this change does not affect Florida's compliance with the federal law. As to its impact on small employers, see Economic Impact, below. However, the criteria that the one-person small employer not be formed primarily for the purposes of buying health insurance may result in factual disputes, in the event of a carrier's denial of coverage based on such criteria, that will require departmental or judicial intervention to resolve.

3. *Composite Rating Prohibited* -- The bill prohibits small group carriers from using a *composite rating methodology* for employers with fewer than 10 employees. This term is defined in the bill as averaging the impact of the rating factors for age and gender. Currently, the use of composite rating by a small group carrier is optional. The bill would *prohibit* composite rating for employers with fewer than 10 employees. Therefore, the premiums charged for each employee would be required to be based on that employee's age and gender. It would appear to be within the discretion of the employer as to whether the premiums billed to each employee are equal (averaged) or would differ based on that employee's age and gender. (The bill's allowance for carriers to base rates on health status, subject to certain limits, discussed in 1., above, specifically prohibits such adjustments to be charged to individual employees.)

4. *Credit for Administrative Cost Savings* -- The bill adds another rating factor that small group carriers may use, to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. In general, a carrier has higher administrative and acquisition costs for smaller size employers, although many carriers have reduced commissions for groups below a certain number of employers (an issue of controversy as to whether this amounts to an unfair practice under s. 627.6699, F.S.). The bill would allow the carrier to use this rating factor as a credit, based on its experience, subject to department approval. Industry sources state that such factor may result in a rate credit (differential) of between 3 to 5 percent.

5. *Family Size Rating Categories* -- The bill specifies certain family-size categories that a small group carriers may use. The current law allows carriers to base rates on family size, but does not specifically limit the type or number of categories. However, the department has imposed certain restrictions in this regard, requiring that a carrier have only one category for dependent children, regardless of the number of dependent children. The bill would specifically allow a small group carrier to have three categories for: one dependent child, two dependent children, and three or more dependent children, further categorized for employees having a spouse and dependent children or employees having dependent children only. The bill allows a carrier to use *fewer* rating categories for dependent children, but not a *greater* number of categories.

6. *Clarification of Other Applicable Rating Laws* -- The bill clarifies the applicability of additional rate filing procedure and standards for insurers and HMOs, respectively. It clarifies that the additional rating law procedures of ss. 627.410 and 627.411, F.S., apply to health insurance companies and that the rating law procedures of s. 641.31, F.S., apply to health maintenance organizations, that sell small employer coverage.

This bill provides that the act shall take effect July 1, 1999.

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:

The difficult question to answer, which may be the primary policy question, is whether eliminating one-person groups and allowing surcharges and credits based on health status will increase or decrease the total number of small employers and employees covered. Since 1993, small group coverage in Florida increased to include an estimated two million people who were not previously insured.[1] Whether the bill will continue this trend or retard it, is questionable. It may be fair to say that in the short-term, initially lower rates for a small employer with a healthy risk profile is likely to increase the number of small employers willing and able to buy group coverage. However, over the long-run, the impact is likely to be neutral, since employers and employees with greater than average costs may tend to be priced out of their coverage, while employers and employees with less than average claims costs may enjoy comparatively lower premiums that enable them to stay insured. The long-term impact could result in fewer persons covered, to the extent that carriers tend to use surcharges rather than credits, resulting in generally greater rates than currently allowed. However, department approval of a carrier's rates should tend to limit this impact, because the carrier's experience is likely to demonstrate that the "base rate" is too high if it imposes surcharges to a greater degree than credits.

Small group carriers report that their greatest costs are for one-person groups: self-employed individuals and sole proprietors. Limiting guaranty-issue requirements to such groups to an annual open enrollment period is likely to reduce overall costs in the small group market to the benefit of groups of 2-50 employees and to the detriment of self-employed individuals and

[1] Information provided by the Agency for Health Care Administration, 1999 Bill Analysis and Economic Impact Statement.

sole proprietors, particularly those individuals who have health problems that would preclude their ability to obtain coverage in the individual, underwritten market. Currently insured individuals would continue to be protected by the guaranteed-renewability requirements, but rates could be increased based on heath factors, as allowed by the bill.

Small employers who employ persons who have health problems or who experience higher than average medical claims may pay up to 15 percent greater rates than average, which may be about 30 percent greater than those small employers whose claims experience is lower than average. Also, for employees who work for an employer with fewer than 10 employees, “composite rating” would be prohibited. It is not clear whether this change will necessarily affect the premiums that are billed to each employee, because this appears to be within the discretion of the employer. However, it may result in each individual employee being charged the rate associated with his or her age and gender. If this is the case, elderly and middle-age persons will be required to pay higher rates than younger employees which, in combination with up to 15 percent increased rates based on health status, could be a very significant increase.

Employers with healthier than average employees who make fewer claims are likely to experience lower than average rates. This will not necessarily result in a lower premium than the current premium, but they will pay comparatively lower premiums than small employers with greater than average claims costs.

C. Government Sector Impact:

The Department of Insurance may be required to expend additional resources reviewing and approving small group rate filings.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.