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 1060

SPONSOR: Banking and Insurance Committee and Senators King, Holzendorf, and Horne

SUBJECT: Health Insurance Policy Forms

DATE: April 19, 2000 REVISED: _____ _____ _____ _____

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

I. Summary:

Committee Substitute for Senate Bill 1060 substantially amends the laws that apply to health insurance rates, amending ss. 627.410 and 627.411, F.S. These changes exempt large group health insurance forms and rates from the requirement of being filed with the Department of Insurance for approval; exempts unique policy forms for small group policies from rate filing requirements; specifies rate standards in place of broader Department of Insurance discretion to disapprove a rate filing; provide greater allowance for the insurer, rather than the department, to determine whether rating standards are met; and provide greater allowance for an insurer to establish smaller "pools" of policies for which claims experience and rates would be based, rather than being required to merge the experience of all similar policy forms.

By providing greater freedom for health insurers to establish and change rates for policies issued in Florida, the bill is likely to result in rate increases for persons who have health problems and who have greater than average health insurance claims. Such premium increases may be unaffordable and the individual's health condition may prevent them from obtaining a new policy. However, it may encourage more insurers to sell insurance in the state and may result in lower rates, or lower premium increases, for persons who do not experience health problems and who have lower than average health insurance claims.

More specifically, the bill makes the following changes:

- Exempts large group health insurance policy forms which are of a unique character from the requirement that forms be filed with the department for approval.

- Exempts from rate filing requirements rates for forms which are of a unique character, regardless of the size of the group; and rates for policies insuring 51 or more employees, (whether the policy is unique or not).

- Deletes the current grounds for disapproval of a health insurance policy form or rate filing that "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 which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." The bill retains the requirement that benefits must be reasonable in relation to the premium charged, but deletes the authority of the department to make this determination based on certain specified factors. Instead, the bill specifies loss ratio requirements that must be met, which are similar to the minimum loss ratio requirements that are established in the current rules adopted by the department.

- Deletes the current requirement that the claims experience of all policy forms providing similar benefits be combined for all rating purposes. As revised, the insurer would be required to combine the experience of an individual health insurance policy form that is no longer being marketed in Florida with the experience of *at least one other* individual policy form, providing similar benefits, *as determined by the insurer*, which is still being marketed in the state.

- Deletes the current law that prohibits an insurer from filing a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department that it is discontinuing the availability of a policy form.

The bill substantially amends the following sections of the Florida Statutes: 627.410 and 627.411.

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 pursuant to sections 627.410 and 627.411, F.S. Rates must be filed at least 30 days prior to use and the department may initiate proceedings to disapprove the rate within this 30-day period, or within an additional 15-days if extended by the department. The filing is deemed approved at the end of such period if it is not disapproved by the department. These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies. Similar requirements are established in chapter 641, F.S. for health maintenance organizations 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 which 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.]

Health Insurance Rate Filing Rules of the Department of Insurance

The Department of Insurance is authorized to adopt rules for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates, and may exempt policy forms. [s. 627.410(6)(b), F.S.] The department has adopted rules pursuant

to this authority which establish minimum loss ratio requirements for all types of health insurance policy forms. (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. 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.

For over 2 years, the department has attempted to revise their health insurance rating rules which are currently subject to a legal challenge, with an administrative hearing pending. One of the issues addressed in the proposed rules, not addressed in the current rule, is a definition of "viable" as used in the current statute that allows the department to disapprove a premium increase that is "not viable for the policyholder market." A provision of the proposed rule specified that this prohibits: 1) an ultimate premium after the increase that is not within the range of rates actually being charged by other companies for comparable coverage, excluding the highest and lowest rate in the market; 2) more than one premium increase to the affected insureds over a 12-month period; 3) a rate increase greater than 150 percent of medical trend for 2 consecutive years; or 4) a rate increase, for discontinued forms, that exceeds the average rate increase approved over the past 6 months for other similar forms of the company currently available for sale, if any, or if none, the average rate increase approved over the past 6 months on forms with similar benefits currently available for sale offered by other companies.

Certain Rate Filing Practices Prohibited

The statutes prohibit the following rating practices by health insurers: 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. [s. 627.410(6)(d), F.S.] This is designed to prohibit rate increases that are scheduled to increase solely due to age of the policyholder and similar rating practices that result in relatively low premiums when a policy is first issued and significant rate increases over the life of the policy as it is renewed. A similar prohibition is included in the laws that apply to long-term care policies (which provide coverage for nursing homes and lower levels of care). Section 627.9407(7), F.S., provides that for long-term care insurance policies, rates may not be calculated to increase based solely on the age of the insured.

Claims Experience of All Similar Policy Forms Must be Combined

The claims experience of all policy forms providing similar benefits must be combined (or "pooled") for all rating purposes. Prior to discontinuing the availability of a policy form, the insurer must provide 30-days notice to the department and the insurer is prohibited from filing a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department. However, the department may lower the 5-year prohibition if it determines that a shorter period is appropriate. [s. 627.410(6)(d)-(e), F.S.] The department's proposed rating rules include a definition of "similar benefits" which would apply to these statutory requirements.

These requirements are aimed at prohibiting 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 the rates for the group increase, healthy individuals are able to meet underwriting standards in order to buy a similar new policy issued by the same insurer. But, unhealthy individuals would be denied new coverage, and the rates under the old policy would escalate even further due to the declining pool of insureds. Eventually the rates become unaffordable. The practice can then be repeated with the new policy form.

Annual Rate Filing Required

The current law requires that each health insurer make an annual rate filing demonstrating the reasonableness of its premium rates in relation to its benefits. [s. 627.410(7), F.S.] This law prevents an insurer from waiting multiple years to make a significant rate increase and to, instead, require smaller, annual rate increases.

Insurers May Use a "Loss Ratio Guarantee"

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 (see discussion above) and must obtain approval from the department 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. The statute specifies particular requirements for calculating and demonstrating whether minimum loss ratio guarantees are met, including an independent audit by the insurer and authority for the department to establish, by rule, the minimum information reasonably necessary to be included in the report.

The current law provides that insurers may use a loss ratio guarantee for Medicare supplement policies when authorized by rules adopted by the department. However, the department has never authorized the use of a loss ratio guarantee for Medicare supplement policies.

Policies Issued to Small Employers

Policies issued to small employers with 1 to 50 employees are additionally subject to the *modified community rating* requirements of s. 627.6699, F.S., (not amended by this bill). This law prohibits insurers from basing rates for small employers on health status or claims experience and limits variations or differences in rates charged to small employers to five factors: age, gender, geographic location, family size, and tobacco usage.

Exemption for Out-of-State Group Policies

Insurers that issue policies to groups or associations outside of Florida, but which may be sold and marketed to individuals in Florida (who are issued "certificates"), are generally exempt from Florida's rate filing and approval requirements. (see s. 627.6515, F.S.) The department has identified only 4 insurers as currently issuing individual major medical health insurance policies in Florida. An additional 11 HMOs are identified as issuing individual HMO contracts in the state

within their respective geographical service areas. Another 27 insurers have been identified as issuing individual certificates in Florida under out-of-state group policies, which are exempt from the rate filing requirements. However, some of the insurers that are currently marketing coverage in Florida only through individual certificates under out-of-state group policies, also have renewal business for individual policies previously issued in the state, to which Florida's rate riling requirements apply. (See the interim project report by the Banking and Insurance Committee, *Rating Practices of Insurers Issuing Health Insurance Policies and Certificates to Individuals who are Eligible for Guaranteed- Issuance of Coverage,* Report No. 98-05, October 1998). However, the requirements of the laws that apply to policies issued to small employers, summarized above, apply to out-of-state associations covering a small employer in Florida.

However, the laws that regulate Medicare supplement policies apply Florida's rating laws to certificates covering Florida residents under an out-of-state group policy. The definition of "Medicare supplement policy" in s. 627.672, F.S., includes a certificate issued in Florida under a group Medicare supplement policy issued outside the state, and s. 627.6745 requires the rates to be filed with the department in compliance with the applicable loss ratio standards of the Insurance Code.

Similarly, for long-term care policies (nursing home and lower levels of care), 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.

III. Effect of Proposed Changes:

Committee Substitute for Senate Bill 1060 substantially amends the laws that apply to health insurance rates, amending ss. 627.410 and 627.411, F.S. These changes exempt large group health insurance forms and rates from the requirement of being filed with the Department of Insurance for approval; exempts unique policy forms for small group policies from rate filing requirements; specifies rate standards in place of broader Department of Insurance discretion to disapprove a rate filing; and provide greater allowance for the insurer, rather than the department, to determine whether rating standards are met; provide greater allowance for an insurer to establish smaller "pools" of policies for which claims experience and rates would be based, rather than being required to merge the experience of all similar policy forms.

Certain Large Group Form Filings Exempt

The bill, in Section 1, amends s. 627.410(1), F.S., to exempt large group health insurance policy forms which are of a unique character from the requirement that forms be filed with the department for approval. This provision is not limited to a rate filing, but applies to any policy form used by the insurer. The bill accomplishes this by narrowing an exception to a current exemption. Currently, forms of a unique character which are designed for and used with relation to insurance upon a particular subject are exempt from the form filing requirements, *other than as to health insurance*. The bill limits this exception to *individual or small group health insurance.* Small group health insurance is not defined, but is understood to have the same meaning as used

in s. 627.6699, F.S., which means a small employer with 1 to 50 employees. Therefore, health insurance policies issued to large groups (with 51 or more employees or members) would now be exempt if the policy is of "a unique character." The distinction between a policy form that has a "unique character" and a policy form that is similar to a standard policy form may be minimal.

If a policy form is exempt from being filed with the department for approval, the department would be unable to enforce any of the mandatory benefit requirements and other policy requirements for an insurer, except through periodic market conduct examinations or investigations of particular complaints.

Large Group Rate Filings Exempt; **Unique Small Group Rate Filings Exempt**

The bill, in Section 1, amends s. 627.410(6), F.S., to exempt from the rate filing requirements group health insurance policies if the policy forms to which the rate applies are of "unique character which are designed for and used with relation to insurance upon a particular subject ***or*** to benefits under group health insurance policies insuring 51 or more persons and are used at the request of the individual policyholder, contract holder, or certificate holder." The use of the word, "or" in the previous sentence indicates that two categories of policies are exempt from rate filing requirements: (1) rates for forms which are of a unique character, regardless of the size of the group; and (2) rates for policies insuring 51 or more employees, whether the policy is unique or not.

The bill does not amend s. 627.6699, F.S., related to small employer health insurance rates, which may be in conflict with this section. That section imposes modified community rating requirements for small group policies (see Present Situation) which would still apply, but the bill may exempt the insurer from filing the rates with the department for approval if the forms are of a "unique character." However, the legality of a small employer carrier using a policy form of a unique character is also in doubt, due to the provisions of s. 627.6699, F.S., which requires that if a small group carrier offers a particular policy to a small employer it must offer that same policy to all small employers.

Allowance for Segregated Rating Pools

The bill significantly revises the current requirement that the claims experience of all policy forms providing similar benefits be combined for all rating purposes (amending s. 627.410(6)(e) on pages 4-5). As revised, the insurer would, instead, be required to combine the experience of an individual health insurance policy form *that is no longer being marketed* in Florida with the experience of *at least one other* individual policy form, providing similar benefits, *as determined by the insurer*, which is still being marketed in the state. The bill also deletes the prohibition of current law that an insurer may not file a new policy form providing similar benefits for at least 5 years after the insurer provides notice to the department that it is discontinuing the availability of a policy form, subject to the department lowering the 5-year prohibition if it determines that a shorter period is appropriate. (The bill also allows, but does not require the insurer to combine the experience of similar policy forms in the filing.)

These changes provide greater freedom to an insurer to have separate, segregated rating pools for its policies. That is, the claims experience and the rates based on such experience would be

segregated into groups with a smaller number of insured lives within each group. This will allow for a much greater variation in the rates charged by the insurer among its various policy forms, likely to result in lower rates for new policy forms and higher rates for policy forms that are no longer being marketed. (See the discussion in Present Situation above as to the "death spiral" rating practices that the current law is intended to prevent.)

Standards for Disapproval of Rate Filings

The bill amends s. 627.411, F.S., (on page 10), to delete the current grounds for disapproval of a health insurance policy form or rate filing that "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 which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." The bill retains the requirement that benefits must be reasonable in relation to the premium charged, but deletes the authority of the department to make this determination based on certain specified factors. Instead, rates shall be deemed to be reasonable in relation to premiums if certain loss ratio tests are met (on pages 10-15).

The loss ratio requirements in the bill are inserted in two different sections, but must be read together. The first reference to specific loss ratio tests appears as an amendment to s. 627.410(7), F.S., (on pages 5-7). These are amendments to the current requirement that insurers make an annual rate filing demonstrating the reasonableness of benefits in relation to premiums charged. In this provision, the bill establishes two loss ratio tests that must be met for an insurer to be deemed to meet this requirement and *eliminates* the requirement that the filing otherwise meet applicable rating laws and rules. The two loss ratio tests are taken from a 1983 publication of the National Association of Insurance Commissioners (NAIC), *Guidelines for Filing of Rates for Individual Health Insurance*. According to the department, these guidelines are in the process of being amended and do not represent the current NAIC position.

One of the substantive differences between the loss ratio standards of the bill, as compared to the current rule, is that the current rule would not allow an insurer to increase rates solely to make-up for experiencing a higher loss ratio in the previous year than the policy was required to have. That is, each year must stand on its own under the current rules and the insurer is required to meet the minimum loss ratio for each year independently and also meet the minimum loss ratio requirements for the life of the policy. If the insurer has a "bad year" and pays out more in benefits than it was required to provide under the minimum loss ratio requirement for that year, the insurer cannot raise rates the following year solely to gain back the profit that it was permitted to make the previous year. However, the loss ratio tests in the bill would allow this.

The bill provides (on page 6) that "the present value of benefits may, at the insurer's option, include recognition of the policy reserve as a benefit (addition), or the present value of premiums may, at the insurer's option, include recognition of the policy reserve as a deduction." Such options could result in different rate increases for carriers with identical experience, depending upon which option they choose. According to the department, this is inconsistent with the NAIC guideline used as the source, which provides that this is additional information the department may review in making a determination, rather than an option of the company.

The bill also provides that anticipated loss ratios *lower* than those indicated require justification based on applicable special circumstances. (Lower loss ratios result in higher rates, because it allows a lower percentage of the premium to be used to pay benefits.) The bill lists specific examples of coverages and other factors that may require special consideration, but the justification for lower loss ratios are not subject to specific standards. It is not clear to what extent these determinations may be made by the insurer or must be made by the department.

The bill provides that for premium rates charged for *group* policy forms, benefits shall be deemed reasonable in relation to premium charged if the anticipated loss ratio over the entire *future* period for which the revised rates are computed to provide coverage meets or exceeds specified loss ratio standards. (page 7, lines 14-19). This means that for group coverage, the loss ratio requirements only apply for the future period. This is generally viewed as consistent with sound actuarial practices and industry practice for "true group" policies. However, for those group policies for which rates are based on an issue age basis and thereby pre-fund future aging of the policy, such as Medicare supplement and long-term care and some disability income policies, this may be contrary to standard actuarial practice.

The specific loss ratio percentages in the bill are contained in s. 627.411(2), F.S., (pages 10-15). These minimum percentages apply to the loss ratio tests which are referenced in s. 627.410(7), F.S. The bill provides that premium rates are not excessive if the insurer demonstrates in accordance with generally accepted standards of actuarial practice, satisfaction of the minimum anticipated loss ratios. These loss ratios are similar to the loss ratios required by the current department rules. However, the bill appears to have inconsistent methods for calculating the lifetime loss ratio. The calculation that appears on page 14, lines 12-23, appears to be different from the calculation that appears on page 5, lines 4-18, even though they both are prescribed methods for calculating lifetime loss ratios.

Exemptions from Annual Rate Filing Requirements

The bill provides exceptions to the current requirement that health insurers make an annual rate filing demonstrating the reasonableness of its premium rates in relation to its benefits [amending s. 627.410(7), F.S., on page 5)]. One of the purposes served by this law is to prevent an insurer from waiting multiple years to make a significant rate increase and to, instead, require smaller, annual rate increases. The bill provides that for guaranteed renewable medical indemnity, loss of income, and disability income policy forms, the filing shall be biennial and made no later then 24 months after its previous filing. The bill also exempts *noncancelable policy forms* from the annual rate filing requirement. The term, *noncancelable* is not defined but is generally understood to mean a policy for which the insurer is not permitted to increase the rates.

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:

By providing greater freedom for health insurers to establish and change rates for policies issued in Florida, the bill is likely to result in rate increases for persons who have health problems and who have greater than average health insurance claims. Such premium increases may be unaffordable and the individual's health condition may prevent them from obtaining a new policy. However, it may encourage more insurers to sell insurance in the state and may result in lower rates, or lower premium increases, for persons who do not experience health problems and who have lower than average health insurance claims.

Currently, insurers issuing individual health insurance coverage in Florida through an out-of-state group policy are already exempt from the rating requirements of Florida law, in most cases. However, insurers issuing out-of-state group Medicare supplement policies and, in certain cases, long-term care policies *are* subject to Florida's rating laws when selling coverage to Florida residents. Therefore, the bill may have its most significant market impact on Medicare supplement and long-term care policies, for which an insurer does not currently have a method to avoid state rate regulation.

Other impacts of the bill's changes are more particularly described in Effects of Proposed Changes above.

C. Government Sector Impact:

None or minimal. By eliminating certain discretionary powers of the department, there may be fewer administrative challenges to rate filings made by insurers.

VI. Technical Deficiencies:

The bill appears to have inconsistent methods for calculating the lifetime loss ratio. The calculation that appears on page 14, lines 12-23, appears to be different from the calculation that appears on page 5, lines 4-18, even though they both are prescribed methods for calculating lifetime loss ratios.

VII. Related Issues:

None.

VIII. Amendments:

None.