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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 687

RELATING TO: The Employee Health Care Access Act

SPONSOR(S): Representatives Farkas and Greenstein

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) GENERAL GOVERNMENT APPROPRIATIONS
(4)
(5)

I. SUMMARY:

HB 687 expands the definition of "modified community rating" to include health status, claims experience, and duration of coverage as factors that an insurer may use in setting rates for small employers. The bill provides that rate adjustments for claims experience, health status, or duration of coverage must be applied uniformly to rates charged all employees of the business and cannot be charged to individual employees or dependents or result in a rate for the employer that deviates more than 25 percent from the carrier's approved rate. The carrier may adjust the renewal premium up to 15 percent annually based on these additional factors. In addition, HB 687:

- Authorizes small employer carriers to adjust small employer premiums based on administrative and acquisition expense differences resulting from the size of the group, subject to review and approval of the Department of Insurance; and
- Provides that small employer carrier rating methodologies may include separate rating categories for one, two, or three or more dependent children for family coverage of an employee with a spouse and dependent children or an employee with dependent children only.

The definition of "small employer" is expanded to include every eligible small employer with less than two eligible employees, which is not formed primarily for purposes of buying health insurance, and which elects to be covered under the plan. Coverage begins on October 1 of the year of enrollment, unless the carrier and employer agree to a different date. Spouses and dependent children constitute a single eligible employee if employed by the same small employer.

Finally, HB 687 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 offer small employer coverage.

The bill's effective date is July 1, 2000.

There may be a fiscal impact to this bill which would include costs incurred by the Department of Insurance in reviewing and approving small group rate filings.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [x] N/A []

HB 687 requires the Department of Insurance to be responsible for reviewing additional rate factors of small employer health benefit plans.

2. Lower Taxes Yes [] No [] N/A [x]

3. Individual Freedom Yes [] No [] N/A [x]

4. Personal Responsibility Yes [] No [] N/A [x]

5. Family Empowerment Yes [] No [] N/A [x]

B. 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" benefit 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 "basic" policy includes certain standard policy specified benefits, certain restrictions on the benefits and utilization, as well as other features designed to lower the cost of this coverage. 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.).

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.

Preexisting Conditions: Differences between Individual and Group Health Insurance Policies

Under current Florida law, section 627.6045, F.S., prohibits *individual* health insurance policies from excluding coverage for a preexisting condition for any period longer than 24 months, based upon a condition that had manifested itself during the previous 24-month period in such a manner as would cause an ordinarily prudent person to seek medical advice or treatment. Insurers are also required to provide credit for preexisting conditions for the time a person was covered under previous coverage that was similar to or exceeded the coverage under the new policy, if such previous coverage was effective within the 62 days prior to the effective date of new coverage.

By comparison, under current Florida Law, *group* policies may not exclude coverage for longer than 1 year, based on a condition manifesting itself during the previous 6 months; and credit must be provided for time covered under previous coverage that was effective within 63 days prior to the new coverage, under s. 627.6561, F.S. Small group policies with 2-50 employees may also impose a 1-year exclusion on preexisting conditions. For small groups with 1, a 24-month exclusion and a 24-month look-back is permitted under s. 627.6699(5)(g)3., F.S. Limitations for preexisting conditions do not apply to out-of-state large group policies covering Florida residents, however they do apply to policies that cover small groups. Presently, insurers in Florida are allowed to consider pregnancy as a preexisting condition.

Evaluation of Health Insurance Market Reforms

General conclusions of the results of insurance reform laws are difficult to make. Many components of insurance reform laws interact with other components of insurance regulation and many times the market and social conditions affect the outcome. In the past few years several studies, both academic and governmental, have been conducted to evaluate heath insurance market reforms and their affects on the health insurance market.

In 1998, the Center for Risk Management and Insurance Research at Georgia State University, funded by the Health Insurance Association of America, conducted a study and found that two types of state regulations have had the greatest affect on the structure of local health insurance markets -- mandates and small group reforms. One major conclusion of the study was that “small-group community rating, in conjunction with a guaranteed issue requirement, is associated with a significantly increased probability that an individual will lack health insurance. The use of small-group rating bands coupled with guaranteed issue is also associated with an increased probability that an individual will lack health insurance...”

In 1999, Wake Forest University School of Medicine, funded by the Robert Wood Johnson Foundation, conducted a study of health insurance reforms. The study primarily focused on small-group and individual policies. The study indicated that “small-group reform laws have had a significant positive impact on the ability of very small ‘micro’ groups of 5 or fewer workers to obtain group coverage. However, most insurers continue to resist selling to groups this size because of greater administrative cost and adverse selection concerns.”

In its separate analysis of the results of insurance reform laws in Florida only, the Wake Forest study concluded that Florida insurance reform laws “have not produced a huge influx of new subscribers....Only increased enrollment for micro groups...” The study also concluded that small-group insurance availability in Florida appears to be hampered “by practices such as covert field underwriting and explicit reduction in agent commissions to discourage enrollment of micro groups. These and some other more isolated practices appear to constitute manipulation, circumvention, or perhaps outright violation of the law. Their aggregate impact is undetermined, however, and may be significantly blunted by the ready ability to obtain coverage through the Community Health Purchasing Alliance (CHPA).”

With regard to affordability of insurance in Florida, the Wake Forest study concluded that “small-group reform has not had a strong negative impact on affordability in Florida. The market is intensely price competitive. Despite some dramatic price increases for a number of insurers and subscribers, and despite fluctuations in price in different years, the overall trend of price in Florida appears to be moderate.”

In August 1999, the Florida Senate Committee on Banking and Insurance published an interim project report, *Review of Florida's Health Insurance Laws Relating to Rates and Access to Coverage* (Report 2000-04). The study determined that:

> Florida has consistently had a lower percentage of persons with employer-based coverage as compared to the national average....The number of persons insured under small group policies in Florida has steadily increased from approximately 163,000 in 1993, when the small group insurance reforms were enacted, to 1.7 million individuals, as of March 1999. Currently, 90 carriers are offering small group coverage, which reflects a fairly healthy market providing small employers with a competitive product. [According to the Florida Department of Insurance, as of March 2000, there are currently over 60 but less than 65 carriers with forms and rates filed in the small group market in Florida.]

In 1998, the Florida Legislature, seeking detailed information about the health insurance circumstances of the geographic, occupational, economic, and ethnic subgroups of the state, authorized the Florida Health Insurance Study (FHIS). The Agency for Health Care Administration (AHCA) was assigned responsibility for managing the project. A research team based in the Department of Health Services Administration at the University of Florida was selected as the primary contractor for the study design and implementation. From March 1999 to September 1999, the University of Florida conducted a large-scale telephone survey of the health insurance status of Floridians under age 65. The team surveyed over 14,000 households consisting of approximately 37,000 individuals. The team also surveyed community clinics, programs and other "safety net" resources that provide medical care services to the poor and uninsured. The team also conducted in-person interviews in three areas known to have high rates of uninsured. A preliminary report of the study was released on January 14, 2000. The study determined that:

> Statewide, approximately 16.8 percent of Floridians under the age of 65 lack health insurance coverage. This translates into 2,084,987 individuals....Among Floridians without health insurance, the most commonly cited reason for lack of coverage was cost: 74.1 percent of uninsured Floridians (1,544,976 individuals) reported an inability to afford the premiums as the main reason for lack of coverage.... Employment is no guarantee of health insurance coverage. The uninsured rate for individuals in households in which at least one person is employed is 16.4 percent, only slightly lower than the 19.4 percent uninsurance rate for individuals in households in which everyone is unemployed.

Florida Insurance Mandate Requirements

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated [health] benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the mandates, the Legislature in 1987 called for a "systematic review of current and proposed"

mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the thirteen years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration--has been largely ignored. [s. 624.215, F.S.]
[*Source: House Committee on Insurance, Interim Project Report, "Managing Mandated Health Benefits: Policy Options for Consideration, January 28, 2000.]*

According to the National Conference of State Legislatures, approximately 900 mandates have been passed among all 50 states. Currently, Congress is also considering imposing additional mandates. Many experts warn that the primary reason health care costs are rising is due to this government interference. According to these experts, the greater the number of services mandated, the greater the costs. [*Source: Merrill Matthews Jr. (National Center for Policy Analysis), "Cadillac Care Too Rich for Some," USA Today, May 19, 1999*.]

C. EFFECT OF PROPOSED CHANGES:

N/A

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act. The following subsections and paragraphs of this section are amended:

Paragraph (3)(n) amends the definition of "modified community rating" which currently allows carriers to use adjust premium rates based on age, gender, family composition, tobacco usage, and geographic areas, to also include health status, claims history, and duration of coverage in premium determination calculations.

Paragraph (5)(c) is amended as follows:

Subparagraph 1., relating to availability of coverage, is amended to require every small employer carrier, beginning July 1, 2000, to offer small employer health benefits on a guaranteed-issue basis to two person groups. [Currently, these benefits are available to three to fifty person groups.]

Subparagraph 2., relating to availability of coverage, is amended to require the offer and issue of basic and standard small employer health benefits by expanding the current requirement to offer the coverage to one person groups. Changes the current 30-day annual open enrollment period to a specified open enrollment period from August 1 to August 31 of each year. Requires this change to take effect beginning August 1, 2000. This requirement does not apply to small employers of less than 2 employees which are formed primarily for the purpose of buying health insurance. Requires that this coverage begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. Provides that, for the purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if such person and spouse are employed by the same small employer.

Deletes the requirement that every small employer must, as a condition of transacting business in the state, offer to small employers the standard and basic health benefit plans. Provides that this paragraph does not limit a carrier's ability to

offer other health benefit plans to small employers if their standard and basic health benefit plans are offered and rejected.

Paragraph (6)(b), which provides restrictions relating to premium rates, is amended as follows:

Subparagraph 1., relating to premium rates for small employer carriers, is amended to authorize that in addition to the use of a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area, the rates may also be adjusted as permitted by newly created subparagraphs 6. and 7. [Note: s. 627.6699(5)(j), F.S., requires that the boundaries used by the small employer carrier must coincide with the county lines and a carrier may not apply different rates of small employers located within the same county.

Subparagraph 5., relating to restrictions to premium rates, is created to prescribe the following:

- Prohibits any adjustment in rates charged to individual employees or dependents for claims experience, health status, or duration of coverage.
- Limits such adjustments, for a small employer's policy, to not more than 15 percent from the carrier's approved rate.
- Requires adjustments to be applied uniformly to the rates charged for all employees and dependents of the same employer.
- Permits a small employer carrier to make an adjustment to a small employer's renewal premium due to claims experience, health status, or duration of the coverage of the employees or dependents. Adjustment is not to exceed 10 percent annually.
- Requires small group carriers to report information on forms adopted by rule by the department on a semiannual basis. Information on the reports must enable the department to compare aggregate adjusted premiums actually charged to policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates.
- Requires that in the event the aggregate of the adjustment exceeds the premium that would have been charged by the application of the approved modified community rate by 5 percent for the current reporting period, then the carrier is limited to applying such adjustments to only minus adjustments beginning not more than 60 days after the report is sent to the department.
- Requires that for any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by the application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments.

Subparagraph 6., is created to provide that a small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Provides that group size

administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience. Administrative and acquisition factors are subject to department review and approval.

Subparagraph 7., is created to provide that a small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. Provides that a small employer may have fewer, but not greater, numbers of categories for dependent children, than specified in the subparagraph.

Subparagraph 8., is created to prohibit small employer carriers from using a composite rating methodology to rate a small employer with fewer than 10 employees. Defines "composite rating methodology" as a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

Amends paragraph (6)(d), relating to applicability, to limit the application of this section, s. 627.410, F.S. (relating to the filing and approval of forms), and s. 627.411, F.S. (relating to grounds for disapproval by the department), to a small employer carrier that is an insurer. Applies this section and s. 641.31, F.S. (relating to HMO contracts), to any health benefit provided by a small employer carrier that is a health maintenance organization.

Section 2. Provides for an effective date of July 1, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

There may be a fiscal impact to this bill which would include costs incurred by the Department of Insurance in reviewing and approving small group rate filings.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the Agency for Health Care Administration:

The bill could increase small group health benefit rates and result in fewer small employers and employees being able to afford health insurance. The bill could also make health insurance less accessible to the one person groups.

The bill allows small employer carriers more profitability in the small group market by: using additional factors in determining premium rates; curbing the ability for individuals to apply for small group coverage solely for guarantee-issue group insurance by imposing specific enrollment dates; and using different rating factors for dependent children according to number of dependent children on a small group policy.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

The Department of Insurance expressed the following technical comments:

- The use of the term “health status” (page 4, line 5) as a rating factor is troublesome since it could result in surcharges based solely on the existence of a member’s health condition without regard to whether or not claims have actually been filed.

- The use of “duration” (page 4, line 5) as a rating factor was specifically prohibited in 1993, because it results in bidding a low entry rate with a scheduled increase in the second year. This type of scheduled increase, along with experience and inflation, resulted in significant increases such that the practice was banned. This conflicts with s. 627.410(6), F.S., prohibiting duration as a rating factor.
- Allowing two rating deviations, +/- 15 percent from the filed community rate, allows permitted health contracts to have rates that are up to 35 percent apart. Within the +/- 15 percent rate is a 10 percent rate adjustment due to renewal only. These changes will result in new issue rates and renewal rates being different.
- Requiring twice a year reporting, analysis, and follow-up with companies will produce increased enforcement responsibilities for the department which could produce increased costs which cannot be specifically estimated.
- Permitting a rate credit to be applied to recognized administrative savings in the larger sized groups which is outside the +/- 15 percent maximum rate charge can result in a group experiencing a rate increase of close to 50 percent plus any additional increase due to trend. Because the maximum renewal increase cannot exceed 10 percent due to claims experience, the 50 percent increase would be spread out over several years with 21 percent increase plus trend in the first year, and 10 percent increase plus trend thereafter.

According to the department, this bill will alter the structure of rate regulation in the small group market. It is likely to result in unaffordable rates and premium costs for some small groups with less attractive risk profiles.

The rate regulation changes may well create more competitive pricing for selected groups while producing less competitive pricing for other small groups.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

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