The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Banking and Insurance Committee

BILL:	CS/SB 266
INTRODUCER:	Banking and Insurance Committee and Senator Baker
SUBJECT:	Medicare Supplement Policies
DATE:	March 20, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Fav/CS**
2.			HP	
3.				
4.				
5.				
6.				

I. Summary:

The bill redefines the term "Medicare supplement policy" for purposes of the Florida Medicare Supplement Reform Act (ss. 627.671—627.675, F.S.), to exclude from regulation under this act, a policy or plan of one or more employers that have at least 50 employees at issue, or trustees of a fund established by one or more employers for employees or former employees.

This bill substantially amends the following sections of the Florida Statutes: 627.672.

II. Present Situation:

Regulation of Medicare Supplement Policies

A "Medicare supplement policy" is defined under Part VIII of chapter 627, F.S., as a health insurance policy or other health benefit plan offered by a private entity to individuals entitled to receive Medicare benefits. A Medicare supplement policy provides reimbursement for expenses incurred for services and items which are normally eligible for payment under Medicare, but are not reimbursable because of deductibles, coinsurance amounts, or other limitations imposed by Medicare. The definition of "policy" in Part VIII includes a certificate issued or delivered in Florida under a group Medicare supplement policy which has been effectuated within or outside this state. Therefore, the provisions of Part VIII apply to out-of-state group policies that cover Florida residents.

Part VIII of chapter 627, F.S., contains various requirements that are designed to provide consumer protections to the policyholders of Medicare supplement policies:

Section 627.273, F.S., requires a Medicare supplement policy to comply with the requirements of this part, subject to administrative fines,[1] the insurer being required to cease marketing Medicare supplement policies related to the violation, or other actions necessary to ensure compliance.

Advertisements for Medicare supplement policies must be filed with the Office of Insurance Regulation (OIR), to ensure that the advertisements comply with the unfair trade practices provisions of Part IX of chapter 626, F.S., or any rule of the Financial Services Commission (commission).[2] If the OIR determines that the advertisement is non-compliant, it may enter an immediate order requiring that use of the advertisement be discontinued. The insurer may request a hearing be conducted by the OIR within 10 days of the entry of an order. The office may impose an administrative fine of up to $10,000 in lieu of revocation of the insurer's certificate of authority, and require that the insurer provide an acceptable clarification of the advertisement to each individual applicant prior to accepting any application received in response to the advertisement.

Medicare supplement policies must meet the minimum standards set forth in rules adopted by the commission, pursuant to s. 627.674, F.S. These standards set forth specific requirements and disclosures which must be made by the insurer to the certificate holder. The minimum standards must meet or exceed the requirements of 42 U.S.C. s. 1395ss (Federal standards for Medicare supplement policies), or the most recent version of the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act. Some of the standards required of a Medicare supplement policy contained in this section are that it:

- cannot define Medicare eligible expenses more restrictively than Medicare does;
- be written in language easily understood by purchasers;
- be accompanied by an outline of coverage in the form prescribed by the NAIC;
- contain a prominently displayed notice of any coordination-of benefits clause that might restrict payment; and
- be accompanied by a copy of the Medicare Supplement Buyer's Guide developed by the NAIC and the Health Care Financing Administration of the United States Department of Health and Human Services.

There are a variety of filing requirements placed on insurers providing Medicare supplement insurance in this state. An insurer providing group Medicare supplement insurance benefits to a Florida resident must file a copy of the master policy and any certificate used in the state as though the policy were issued in the state. Every entity providing Medicare supplement insurance coverage must report the policy and certificate number and date of insurance for every Florida resident for which the entity has more than one such policy or certificate.

Part VIII also contains provisions for the issuance, cancellation, non-renewal, or replacement of the policy.[3] An insurer may not cancel or non-renew an individual or group Medicare supplement policy for any reason other than nonpayment of premium or material

[1] Section 624.4211, F.S. The administrative fine may be up to $2,500 for a non-willful violation, up to an aggregate of $10,000 arising out of the same action; for a willful violation, the fine may be up to $20,000 up to an aggregate of $100,000 arising out of the same action.
[2] Section 627.6735, F.S.
[3] Section 627.6741, F.S.

misrepresentation. Additionally, a Medicare supplement policy generally cannot limit or preclude liability under the policy for more than 6 months due to a medical condition that pre-exists the policy's effective date. Also, if a group Medicare supplement policy is terminated by the group policyholder and is not replaced by another policy, the insurer must offer certificate holders an individual Medicare supplement policy.

Each year, an entity providing Medicare supplement policies must file its rates, rating schedules and documentation demonstrating compliance with the applicable loss ratio standards of the insurance code. For group policies, the rates must be set at a level so that at least 75 percent of the aggregate amount of earned premiums are expected to be returned to the policyholders in the form of aggregate benefits under the policy, over the lifetime of the policy.[4] For group health insurance policies issued in Florida other than Medicare Supplement policies, the loss ratio requirement is 75 percent for groups with more than 500 certificates, 70 percent for groups with 51 to 500 certificates, and 65 percent for groups with 50 or less certificates.[5] Higher loss ratios requirements result in lower premiums for the policyholder. Other sections contain provisions for permitted compensation arrangements and standards for marketing.

No coverage which is required by Florida law for individual or group disability (health) insurance policies applies to a Medicare supplement policy unless it is specifically made applicable to Medicare supplement policies.[6]

Federal law also regulates Medicare supplement policies under 42 U.S.C. 1395ss, requiring that a Medicare supplement policy be regulated under state law pursuant to the requirements of federal law or the 1991 MAIC Model Act. Notably, federal law excludes policies provided by employer groups and labor organizations from the definition of "Medicare Supplement policy." The NAIC Medicare Supplement Insurance Minimum Standards Model Act also excludes policies issued to an employer group, its employees or former employees, or labor organizations' members or former members. This exclusion was a part of Florida law until 1987 when the NAIC amended its model law to include employer group and labor union policies. The NAIC reversed itself in September 1988, and restored the employer group and labor organization exclusion, to make the NAIC models consistent with federal law. The Florida law was revised to include the exclusion for labor union groups in Chapter 2000-202, Laws of Florida, but the statutes do not exclude employer groups. States that exempt both employer groups and labor unions nationwide include but are not limited to California, Massachusetts, Texas, Virginia, Pennsylvania, Arizona, Georgia, and South Carolina.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.672, F.S., to exclude from the definition of Medicare supplement policy any, "policy or plan of one or more employers that have at least 50 employees at issue" created for the benefit of employees, former employees, members, or former members.

By excluding policies or plans for Medicare supplement insurance provided to employers from the definition of "Medicare supplement policy" (whether the policy was issued in Florida or

[4] Section 627.6745, F.S.
[5] 69O-149.005(4)(b), F.A.C.
[6] Section 627.675, F.S.

issued to an out-of-state group) the state Medicare supplement requirements of part VIII of chapter 627, F.S., as described in Present Situation above, would not apply to such policies or plans.

However, if the Medicare supplement policy is issued to an employer in Florida, it appears that the provisions of the Insurance Code that apply to insurance policies in general and to "health insurance" policies in particular, other than those in Part VIII of chapter 627, F.S., would continue to apply. For example, rates and policy forms for health insurance are subject to filing and approval by the Office of Insurance Regulation pursuant to ss. 627.410 and 627.411. These include a requirement that the rate structure must be based on the issue age of the insured, to protect policyholders from rate increases each year simply due to advancing age.[7] Additionally, the 75 percent minimum loss ratio standard for group Medicare supplement policies would no longer apply, which is a higher standard than those (adopted by rule) for other classifications of group insurance for all but the largest of groups.

If the policy is issued to an employer outside of Florida, the department would not have regulatory authority to assist Florida insureds who have problems or complaints with the insurer. However, any policy issued to such an employer would still be required to comply with the applicable laws of the state where the master group policy is issued.

Section 2. The act takes effect on July 1, 2007.

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:

Representatives from the Office of Insurance Regulation have expressed concerns with the bill, stating that consumer protections would be lost for policies obtained through an employer group. According to the OIR, such policies would not be required to meet the

[7] Section 627.410(6)(d)3., F.S.

form, rate regulation, or marketing protections contained in Florida law. The OIR is also concerned that smaller businesses may not have educated fiduciaries making the group policy purchasing decisions for some employer group policies.

Proponents of the legislation assert that employers have a sufficient level of expertise to be afforded the same exemption given to labor organizations regarding Medicare supplement policies. Such proponents note that it would allow employers to negotiate nation-wide group coverage, instead of being forced to have a Florida-specific Medicare supplement policy. Additionally, the premium would be based on the benefit level that the employer, thus affording flexibility to employers who wish to provide this benefit.

C. Government Sector Impact:

The Office of Insurance Regulation states that the bill would have no fiscal impact for the OIR. Staff concludes that OIR would continue to receive rate and form filings for employer group Medicare supplement policies, but the statutory grounds for approval are revised.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.