HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 675 Medicare Supplement Policies
SPONSOR(S): General Government Policy Council, Health & Family Services Policy Council, Workman and others
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Insurance, Business & Financial Affairs Policy Committee	16 Y, 1 N	Reilly	Cooper
2)	Health & Family Services Policy Council	23 Y, 0 N, As CS	Ciccone/Lowell	Gormley
3)	General Government Policy Council	15 Y, 0 N, As CS	Reilly	Hamby
4)				
5)				

SUMMARY ANALYSIS

Under Federal law, Medicare beneficiaries age 65 and older, who are also enrolled in Medicare Part B, have a guaranteed right to buy Medicare supplemental insurance (Medigap insurance) during an open enrollment period. Medigap policies help pay some of the health care costs not covered by Medicare, including copayments, coinsurance, and deductibles. This guaranteed right does not extend to Medicare beneficiaries under the age of 65. However, federal law does not preclude states from making Medigap insurance available to these Medicare beneficiaries.

The bill requires insurers that offer Medicare supplement insurance policies in Florida to issue these policies on a guarantee-issue basis during the open enrollment period to an individual who is under the age of 65, eligible for Medicare by reason of disability or end stage renal disease, and enrolled in Medicare Part B.

The bill provides two significant changes to rate-making procedures related to under-65 Medicare supplement policies. First, companies that have offered such policies before October 1, 2009, are provided a one-time opportunity to redefine the age bands used for their premium classes which include ages under 65. They may do this without activating the provisions of s. 627.410(6)(e)2, F.S., which bars insurers that discontinue a policy form from offering a similar policy in the state for 5 years.

Second, up to and including the first rate filing in 2015, insurers may adjust rates for under-65 beneficiaries separately from the age 65 and over beneficiaries, and based on a smaller number of policies than is generally required to justify a rate change in Florida.

After 2015, experience will be pooled throughout the block according to OIR's rating rules, including Medigap policyholders under age 65, resulting in potentially higher premiums to current Medigap policyholders.

The bill does not appear to have a fiscal impact on state or local governments.

The bill is effective October 1, 2009.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS
I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicare Coverage

The Medicare Program was established in 1965 under Title XVIII of the Social Security Act, as a social insurance program to provide health and financial security for persons age 65 and older. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities and persons with end stage renal disease (ESRD). Medicare eligibility was further expanded in 2001 to include persons with amyotrophic lateral sclerosis.

There are four components of Medicare coverage:

- Part A provides coverage for inpatient hospital care, skilled nursing care (not custodial or long-term care), hospice, and home health care.
- Part B provides coverage for doctors' services, outpatient care, and some preventive services such as exams, lab tests, and immunizations to help prevent, find, or manage a medical condition. Part B is optional coverage.
- Part C or Medicare Advantage Plans provides Part A (Hospital) and Part B (Medical) coverage through Medicare-approved private companies—some companies also provide Part D (prescription drug) coverage.
- Part D provides coverage for prescription drugs through Medicare-approved private health plans.[1]

In Florida, approximately 3.1 million persons (2,699,180 age 65 and older and 429,344 disabled) were covered by Medicare in 2007.[2] Another 2007 survey, conducted by the U.S. Census Bureau, reported that Medicare provided coverage for 485,000 people in Florida under the age of 65.[3] Based on data from the same report, more than 55 percent of this population had secondary coverage—33 percent (161,000) had secondary coverage with a private insurer, while 22 percent (108,000) had secondary coverage with Medicaid.

[1] http://www.floridahealthfinder.gov/seniors/senior-health.shtml (last visited March 29, 2009) and "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," Centers for Medicare & Medicaid Services (CMS) (2009). Found at http://www.medicare.gov (last visited March 30, 2009).
[2] Medicare Aged and Disabled by State and County, as of July 1, 2007. See www.cms.hhs.gov (last visited March 29, 2009).
[3] "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau.

Social Security Disability

The Social Security Act of 1981 provides that in order for an individual to be deemed disabled, the individual must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that is expected to result in death or has lasted, or can be expected to last, for a continuous period of 12 months. There are two programs under which Social Security pays disability benefits:

- Social Security Disability Insurance (SSDI) for insured workers, their disabled surviving spouses, and children (disabled before age 22) of disabled, retired, or deceased workers.
- Supplemental Security Income (SSI) for the aged, the blind, and people who have disabilities and very low income.

Medigap Coverage

A Medicare supplement insurance policy ("Medigap" policy) is private health insurance that is designed to supplement original Medicare plan coverage. Medigap policies help pay some of the health care costs that the original Medicare plan does not cover. Every Medigap policy must follow Federal and state laws and must be identified as "Medicare Supplement Insurance."[4]

Under federal law,[5] Medicare beneficiaries age 65 and older, who are also enrolled in Medicare Part B,[6] have a guaranteed right to purchase a Medigap policy during an open enrollment period.[7] Medigap insurance companies may only provide a "standardized" Medigap policy identified by letters "A" through "L." Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. Cost is usually the only difference between Medigap policies sold by different insurance companies. Medigap insurance helps pay some of the health costs not covered by Medicare, including copayments, coinsurance, and deductibles. The open enrollment period for Medigap insurance is six months, beginning on the first day of the month the beneficiary is both age 65 or older and enrolled in Medicare Part B.[8]

The guaranteed right to buy Medigap insurance is limited to persons who qualify for Medicare based on age and does not extend to Medicare beneficiaries under the age of 65. States, however, are not precluded from making Medigap insurance available to under-65 beneficiaries. At present, 28 states,[9] to varying degrees, make Medigap insurance available to Medicare beneficiaries under the age of 65,[10] and all provide for the open-enrollment period. Ten of these states passed such legislation within the past 10 years.[11]

According to a recent report by a major rating agency, consumers in Florida (followed closely by New York) are charged the most for basic Medigap policies, upwards of more than twice what consumers pay in Utah and Maryland.[12] For example, the average annual quote for a "plan A" policy (the most

[4] "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," CMS (2009). Found at http://www.medicare.gov (last visited March 30, 2009)
[5] 42 U.S.C. 1395ss.
[6] Medicare Part B helps cover doctors' expenses and outpatient care.
[7] Medicare beneficiaries may be able to purchase Medigap insurance after the open enrollment period has ended. However, insurance companies can use medical underwriting criteria in determining whether to issue a policy.
[8] "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," CMS (2009). Found at: http://www.medicare.gov (last visited on March 2, 2009).
[9] California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin.
[10] According to a Florida Renal Coalition fact sheet, "Medigap for People with Kidney Failure under Age 65," California, Massachusetts, and Vermont do not authorize Medicare beneficiaries under 65 with ESRD to purchase Medigap insurance. By contrast, Delaware's under-65 Medigap authorization extends solely to Medicare beneficiaries with ESRD.
[11] The ten states are California, Colorado, Delaware, Hawaii, Illinois, Kentucky, Maryland, South Dakota, Vermont, and Washington.
[12] " Florida and New York Residents Charged Most for Medigap Policies Utah and Maryland Residents Charged Far Less." Found at http://www.thestreetratings.com/News/Ins_Medigap/20000612medigap.htm (last visited March 31, 2009).

basic, with preventive care and hospital and physician coinsurance coverage) is approximately $1,050 in Florida. The same plan in Maryland would cost approximately $593.

End Stage Renal Disease (ESRD) Population

According to the United States Renal Data System (USRDS), there are 406,812 ESRD patients in the United States, as of December 31, 2005.[13] Between 2005 and 2006, the greatest increase in new ESRD patients occurred among those age 20-44 (2.7 percent), 45-64 (6.1 percent), and 65-74 (3.5 percent). The numbers in each of these groups represent the highest growth observed in the last five years.[14]

Total Medicare spending in 2006 was approximately $355 billion, while ESRD costs rose to $23 billion—6.4 percent of the total Medicare budget. This number has not changed over the past four years. This stability of costs is a result of comparable growth in both the Medicare and ESRD programs, which has kept proportional costs constant.

Comparison of Per Person Per Year Estimated Costs		
Age	**Non-ESRD Medicare Patients**	**ESRD Medicare Patients***
20-44	$5,470	$49,678
45-54	6,701	56,891
55-64	6,993	
65-74	6,009	66,280
75+	9,766	75,006
*Primary payor and primary diagnosis only.		

Recent Studies

A 1998 report by Abt Associates Inc., "Expansion of Medigap to Under-65 Medicare Beneficiaries Could Increase Access at Little Cost,"[15] studied 16 states that at that time required open enrollment for Medicare beneficiaries under age 65, and concluded in part that "extending a six month open enrollment period to the under-65 population will have little effect on premium levels, and will result in little or no disruption to the Medigap market." However, the study did note that the expansion is "associated with an increase of 2.1 percent in premiums for aged beneficiaries."[16]

In 2008, the University of South Florida at St. Petersburg published a "Medigap Expansion Study"[17] based on the ten states that had enacted Medigap legislation for under-65 Medicare beneficiaries subsequent to the 1998 Abt study. The results were consistent with what was found in the 1998 study.

The study reports that more than 11,000 Florida Medicare beneficiaries under 65 have ESRD. Of these, more than 80 percent have secondary insurance coverage. Approximately 2,000 of these beneficiaries lack secondary insurance.

Additional findings include:

- Nationally, 8 percent of Medicare beneficiaries under the age of 65 who are able to purchase Medigap insurance do so (compared with 28% for Medicare beneficiaries aged 65 and over).
- Medicare beneficiaries without secondary coverage may not adhere to treatment plans and subsequently require more expensive hospitalization and emergency room services.
- Transplant centers generally require those without secondary insurance to pay $1,000 to $5,000 to be placed on the transplant waiting list. Thus, Medicare beneficiaries who cannot afford this

[13] U.S. Renal Data System, "USRDS 2008 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States," National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2008.
[14] *Id.*
[15] Study available at http://www.abtassociates.com (last accessed March 3, 2009).
[16] *Id.*
[17] Jessica Cabness & Richard Smith, University of South Florida, "Medigap Expansion Study" (2008).

cost continue to receive expensive dialysis treatment indefinitely. (Florida citizens with ESRD who are on dialysis have three treatments per week.)

- Financial costs to Medicare beneficiaries without secondary insurance include the Medicare Part A deductible of $1,086 for each hospitalization, Part B's $135 annual deductible, and the 20 percent charge after Medicare for other outpatient medical treatment.
- The Medigap expansion will not change demand level for treatment or service, and will allow Medicare beneficiaries with adequate incomes to avoid spending down their assets to access the state's Medicaid program.[18]

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups. Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. Florida currently has at least[19] 48 mandates, ranking 13th highest in the nation for the number of mandates.[20] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. Costs of health insurance in Florida average $10,848 per year for a family in the small group market. This amount is somewhat higher than the national average of $9,768.[21]

Florida enacted s. 624.215, F.S., to take into account the impact of insurance mandates and mandated offerings on premiums when making policy decisions. The section requires that any proposal for legislation that mandates health benefit coverage or mandatorily offered health coverage must be submitted with a report to AHCA and the legislative committee having jurisdiction. The report must assess the social and financial impact of the proposed coverage, including, to the extent information is available, the following:

- To what extent is the treatment or service generally used by a significant portion of the population.
- To what extent is the insurance coverage generally available.
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service.
- To what extent will the coverage increase the appropriate uses of the treatment or service.
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.

[18] In 2003, Florida spent $10,348 for every disabled person who was eligible for both Medicare and Medicaid.
[19] Depending on how liberally the term is defined, an alternate count indicates that there are 51 health insurance mandates in Florida. "Expanding Opportunities for Health Insurance Coverage in Florida," Michael Bond, Ph.D., James Madison Institute. Found at http://www.jamesmadison.org/pdf/materials/548.pdf (last visited March 2, 2009).
[20] "Health Insurance Mandates in the States 2008," Council for Affordable Health Insurance. Found at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf (last visited March 2, 2009).
[21] "Health Insurance: Overview and Economic Impact in the States," Americas Health Insurance Plans (2007).

The bill requires an insurer offering Medigap policies in the state to offer an individual who is under age 65 and who is disabled or has ESRD the option of enrolling in a Medigap policy. Consequently, this provision appears to be a mandated offering that falls within s. 624.215, F.S.

Effect of Proposed Changes

The bill amends s. 627.6741, F.S., to require insurers issuing Medicare supplement policies in Florida to guarantee-issue coverage to qualified Medicare beneficiaries who are:

- under the age of 65;
- qualified for Medicare because of disability or end stage renal disease;
- enrolled in Medicare Part B; and
- residents of the state.

The bill specifies that the 6-month period to enroll in a Medicare supplement policy for qualified individuals who were first enrolled in Medicare Part B before October 1, 2009, begins on October 1, 2009. It also provides that qualified individuals must be offered a guarantee-issue Medicare supplement policy during the two-month period following termination of coverage under a group health insurance policy.

Further, the bill provides two significant changes to rate-making procedures related to under-65 Medicare supplement policies. First, companies that have offered such policies before October 1, 2009, are provided a one-time opportunity to redefine the age bands used for their premium classes which include ages under 65. They may do this without activating the provisions of s. 627.410(6)(e) 2, F.S., which bars insurers that discontinue a policy form from offering a similar policy in the state for 5 years.

Second, up to and including the first rate filing in 2015, insurers may adjust rates for under-65 beneficiaries separately from the age 65 and over beneficiaries, and based on a smaller number of policies than is generally required to justify a rate change in Florida.[22] Specifically, policyholder experience will be deemed 100 percent credible if there are at least 1,250 policies in the premium class. Florida-only experience will be deemed 0 percent credible if there are fewer than 250 policies. If there are fewer than 1,250 Florida policies, insurers will be permitted to use both their Florida-only and national experience in submitting a filing for a rate change with the Office of Insurance Regulation.

After 2015, experience will be pooled throughout the block according to OIR's rating rules, including Medigap policyholders under age 65, resulting in potentially higher premiums to current Medigap policyholders.

The effective date of the bill is October 1, 2009.

B. SECTION DIRECTORY:

Section 1. Amends s.627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement.

Section 2. Provides that the bill takes effect on October 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
   None.

2. Expenditures:
   None.

[22] Under the general health rating rule, Rule 69O-149, F.A.C., 2,000 policies are required to achieve full credibility. The experience for 1,250 policies is given 50% credibility, and that for 500 or fewer policies is given zero credibility.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:
None.

2. Expenditures:
None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that expanding eligibility for Medigap insurance increases overall claims cost for an insurer, those costs may be passed through in the form of premium increases. In particular, expanding coverage for persons with disabilities and ESRD under age 65 may increase premiums for beneficiaries age 65 and over by an appreciable amount, in light of the fact that Florida has the highest average cost for basic Medigap policies in the nation.

D. FISCAL COMMENTS:

Correspondence from the Agency for Health Care Administration and the Office of Insurance Regulation indicates that the bill has no fiscal impact on state government. [23]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax sharing with counties or municipalities.

2. Other:
None.

B. RULE-MAKING AUTHORITY:
None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On April 1, 2009, the Health and Family Services Policy Council adopted a strike-all amendment that:

- Expands the mandated coverage offering for Medigap/Medicare supplement policies to persons who are under age 65 and eligible for Medicare due to disability *or* end stage renal disease, and are enrolled in Medicare Part B. The original bill provided coverage to persons under age 65 with end stage renal disease and enrolled in Medicare Part B only.
- Authorizes an insurer who is currently offering an under 65 Medicare supplemental policy to change the description of the age bands of the premium classes one time only without activating the period of discontinuance.

[23] Correspondence on file with the Insurance, Business & Financial Affairs Policy Committee.

- Authorizes an insurer to make rate adjustments for under 65 Medicare supplemental policies separate from the balance of the block until the insurer's first rate filing in 2012.
- Changes the effective date from July 1, 2009 to October 1, 2009.

The analysis is drafted to the council substitute.

On April 14, 2009, the General Government Policy Council adopted four amendments. In addition to a technical change, the amendments:

- Permit insurers, up to and including the first rate filing in 2015, to adjust rates for under-65 beneficiaries separately from the age 65 and over beneficiaries. Previously, the bill provided such authority through the first rate filing in 2012.
- Authorize companies that have offered under-65 Medicare supplement policies before October 1, 2009, a one-time opportunity to redefine the age bands used for their premium classes which include ages under 65, without activating the discontinuance provisions of s. 627.410(6)(e)2, F.S. Previously, the bill provided this opportunity to companies that offer such policies before January 1, 2010.