The Florida Senate

Interim Project Summary 2000-04 *August 1999*

Committee on Banking and Insurance Senator James A. Scott, Chairman

REVIEW OF FLORIDA'S HEALTH INSURANCE LAWS RELATING TO RATES AND ACCESS TO COVERAGE

SUMMARY

Most states, including Florida, enacted health insurance reforms during the 1990's to guarantee access to coverage for certain categories of persons and to protect individuals with health problems from targeted rate increases. These types of reforms rely upon a regulated private insurance market to provide health insurance to persons who do not qualify for publicly-funded programs such as Medicaid, Medicare, or subsidized health insurance programs for children of low-income families. By requiring insurers to provide guaranteed-issue coverage and to use some form of community rating to spread the costs of unhealthy insureds over a large number of policyholders, the law attempts to modify private market behavior that would otherwise seek to avoid high-risk policyholders or charge them higher rates. However, forcing insurers to spread costs to healthy insureds who are not required to obtain insurance may discourage its purchase and result in a minimal or even negative impact on the overall rate of coverage. Such concerns call into question the overall impact of these types of health insurance reforms.

Although the Florida Legislature has enacted several laws designed to increase the number of Floridians who have health insurance through an employer-based plan or through individual coverage, the uninsured rate for the nonelderly in Florida has steadily increased from 21.8 percent in 1995 to 23.7 percent in 1997, and Florida's rate has remained well above the U.S. average for each of the last 3 years. Similarly, Florida has consistently had a lower percentage of persons with employer-based coverage as compared to the national average.

Trends in the individual, small and large group markets in Florida were evaluated. Florida appears to have a fragile and fragmented individual market. Only three health insurers are believed to be actively issuing individual, in-state, major medical insurance policies in the state.

Currently, approximately 1.7 million individuals are insured through the small group market and 90 carriers are offering coverage, which reflects a fairly healthy market providing small employers with competitive products. As of February 1999, 86,766 persons were insured through Community Health Purchasing Alliances (CHPAs), representing a 7,000 decline in the number of persons who were insured in December 1998. This decline appears to be due to a total of 15 insurers and HMOs discontinuing their participation in CHPAs, leaving only 10 carriers.

Coverage for large employers in Florida appears to be widely available and competitive. There is general agreement that large employer size and market competition help protect against rate increases. For employers with 500 or more employees, the carrier and the employer are likely to negotiate an experience rated policy, for which the employer's premiums are based primarily on its own loss experience. For such policies, the department performs a relatively cursory review of the rate filings which are rarely disapproved.

Staff compared Florida's health insurance laws with the laws of fourteen other states: California, Colorado, Connecticut, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Oregon, Pennsylvania, and Texas.

Based on interviews with regulatory officials, many states have implemented specific, but often unwritten administrative guidelines to use for evaluating rate filings. Many states require carriers to meet minimum loss ratio standards, either by statute, rule, or by unwritten administrative guideline.

In all of the 15 states surveyed, some type of rate filing is required for individual health insurance policies. A file and use system is required by 8 states for individual and/or group filings. In general, these states allow rates to be charged without department approval, but the department typically has authority to intervene. Prior

approval is used in 11 states for individual and/or group filings. However, states categorized as prior approval typically provide that rates are deemed approved after a certain time period, if the department does not act. Also, the extent to which state regulators exercise their statutory authority varies greatly among these states.

Four of the fifteen states reviewed have implemented guaranteed-issue for individual coverage. Eight of the states reviewed have a high-risk pool that offers coverage to persons otherwise unable to obtain coverage. Florida, Georgia, and Pennsylvania are the only three states that do not have either guaranteed-issue or a high-risk pool for individual coverage.

The regulation of small groups was diversified among the 15 states. Five states defined small employer to include groups of 1-50. Ten of the 15 states allowed health factors to be considered for purposes of establishing small group rates. In these 10 states, the maximum percentage adjustment allowed ranged from 10 - 25 percent, except for Illinois which does not regulate small group rates and Oregon which does not regulate small groups with 26-50 employees.

Three states do not require a rate filing to be submitted for small group indemnity plans. However, at least nine states require some type of annual rate certification form to be filed.

Ten states did not require rates for large groups (indemnity products) to be filed. In Indiana, large group carriers are required to file rates; however, the rates are not reviewed and the rates are market driven. In Massachusetts, only health maintenance organizations are subject to rate regulation in the large group market. In Minnesota, large group initial or renewal rates are not subject to approval.

It is recommended that the Legislature consider the following options:

Small Group Coverage - To maintain access to coverage for one-life groups and limit the effects of adverse enrollment which occurs when someone waits until a health problem occurs before obtaining coverage, the Legislature should consider providing an annual or semiannual enrollment period of 30 or 60 days for one-life groups.

In answering the question of the extent to which healthy risks should subsidize unhealthy risks, legislators should rely more on their own sense of fairness and equity than on an expectation that the percentage of insured small employers will significantly increase or decrease. Allowing insurers to increase or decrease a small employer's premium due to health factors by a limited amount, such as 10 or 15 percent, may make coverage more affordable for a small employer with healthy risks and provide an incentive to help control claims costs. However, this change is not likely to have a significant impact on the overall rate of employers obtaining coverage and comes at a cost to those employers with greater than average claims costs. In answering the question of the extent to which healthy risks should subsidize unhealthy risks, legislators should rely more on their own sense of fairness and equity than on an expectation that the percentage of insured small employers will significantly increase or decrease.

The CHPAs would have the opportunity to obtain greater savings for small employers if it was issued one master policy and had the ability to negotiate rates and benefits with selected carriers, subject to the same insurance laws that apply to other association groups.

Rating Law - The provision in Florida's rating law that prohibits rate increases that are *not viable to the policyholder market*, should be revised to provide better guidance to insurers and the department.

Large Group Coverage - Deregulation of rates for coverage of large employers above a certain size, somewhere in the range of 100 to 500 employees, should be considered.

Individual Coverage - The Legislature should consider addressing the needs of high-risk individuals seeking health insurance coverage either through guaranteed-issue or a high-risk pool.

Out-of-state coverage - The Legislature should consider applying the same rating laws that apply to individual coverage to out-of-state policies covering individuals in Florida.

BACKGROUND

Individual Health Coverage Reforms

Florida law does not guarantee that all individuals have access to a health insurance policy. Insurers are generally authorized to determine whether to issue coverage to an individual based on his or her health status. From 1983 until July 1, 1991, persons who

could not obtain health insurance coverage due to theirhealth status were eligible to buy coverage from the Florida Comprehensive Health Association (FCHA), a state-created insurer. The FCHA was funded by policyholder premiums capped at 250 percent of the standard risk rate for individual coverage and by assessments against insurance companies. Due to a history of increasing assessments and projections of claims costs growing beyond assessment limitations, the Legislature closed the FCHA to new enrollment as of July 1, 1991, but continued to allow existing policyholders to renew their coverage. At its peak, the FCHA insured more than 6,000 individuals. Today, 864 individuals remain insured with the FCHA.

Guaranteed Renewability — Florida law and federal law require that individual health insurance policies and individual HMO contracts be guaranteed renewable, subject to certain exceptions.

Continuation of Prior Coverage — The federal Health Insurance Portability and Accountability Act (HIPAA) and conforming Florida law allow persons who lose their eligibility for group coverage, after having at least 18 months of coverage, to obtain individual coverage within 63 days after termination of the prior coverage. Under the federal law, the individual's most recent coverage must be under a group plan. Under the more expansive Florida law, a person who loses eligibility for individual coverage also qualifies for new individual coverage, if the prior coverage was terminated because the insurer became insolvent, or the insurer discontinued the offering of all individual coverage in the state, or because the individual no longer lives in the service area of the insurer's provider network, all of which are legal or practical exceptions to guaranteed renewability of the prior coverage.

Florida has adopted two methods for guaranteeing access to individual coverage for "HIPAA-eligible" individuals. These methods apply after an individual has exhausted his or her right to continue coverage under the group plan pursuant to the federal COBRA law, which applies to employers with 20 or more employees, or Florida's "mini-COBRA" law, which applies to employers with less than 20 employees. Under both laws, the group coverage may be continued for up to 18 months, or 29 months for handicapped individuals, or 36 months for divorced or widowed dependents. After the COBRA period ends, a HIPAA-eligible person is provided one of two methods for continuing coverage, depending on the type of prior coverage that was terminated. If the prior coverage was under an employer's insured plan, the group insurer or HMO must offer an individual conversion policy. The group insurer must offer at least two conversion policy options. The premium for a conversion policy may not exceed 200 percent of the standard risk rate, a statewide average rate computed by the Department of Insurance.

Some persons who lose their prior coverage are not eligible for a conversion policy under Florida law. This generally includes persons who were covered under a *self-insured* employer plan, or who move out of the insurer's service area, or who had individual coverage and the insurer either became insolvent or discontinued offering coverage. Florida law entitles these HIPAA-eligible persons to purchase an individual policy on a guaranteed-issue basis from any insurance company or HMO issuing individual coverage in the state. The carrier must offer its two most popular policy forms, by premium volume in the state. Insurers issuing certificates of coverage in Florida under out-of-state group policies are subject to the same guaranteed-issue requirements that apply to insurers issuing individual policies in Florida.

There is no statutory limit on the premium that may be charged HIPAA-eligible persons who are not eligible for a conversion policy. However, the Department of Insurance prohibits carriers from surcharging individuals or otherwise discriminating based on their HIPAA-eligibility status alone. This does not prohibit an insurer from surcharging an individual based on an identified health problem, as long as HIPAA-eligibility status is not used as an independent factor.

Small Group Coverage Reforms

Guaranteed-Issue and Community Rating - In 1992, the Employee Health Care Access Act was enacted to require insurers in the small group market to guarantee the issue of coverage to any small employer (2-50 employees) that applies for coverage, regardless of the health condition of the employees. In 1993, the act was expanded to cover employers with 1 to 50 employees, including sole proprietors and self-employed individuals. The federal HIPAA law similarly requires guaranteed-issuance of small group coverage, but the federal law applies only to employers with *2* to 50 employees.

The Florida act further requires that insurers set rates for small groups on a "modified community rating" basis. A small employer's premium may be based only on age, gender, family composition, tobacco usage, and

geographic location. Rates may not be based on the health status or claims experience of any individual or group.

Community Health Purchasing Alliances (CHPAs) — In 1993, the Florida Legislature established the CHPAs as state-chartered, nonprofit private organizations, intended to pool purchasers of health care together in organizations that broker health plans at the lowest price and enable consumers to make informed selections of health plans. CHPAs make available health insurance plans to small employers. CHPAs, located in eight districts throughout the state, essentially act as clearing-houses for health insurance plans from carriers that elect to participate and respond to requests for proposals.

Rate Regulation for Health Insurance

Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance. The law requires that rates be filed at least 30 days prior to use and authorizes the department to initiate proceedings to disapprove the rate within this period, which may be extended 15 days by the department. The filing is deemed approved at the end of the 30 or 45-day period if it is not disapproved. These requirements apply to individual and group health insurance policies, health maintenance organization contracts, Medicare Supplement policies, and long-term care policies.

The department may disapprove a health insurance rate or form filing if the policy "provides *benefits which are unreasonable in relation to the premium charged*, 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."

Based on the above standard, current department rules establish minimum loss ratios for all types of health insurance policy forms. 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 expected to be paid in benefits and no more than 35 percent for expenses and profit. The minimum loss ratios required by rule range from 55 percent to 75 percent, depending on the type of policy. The rule sets a minimum 65 percent loss ratio for individual health insurance policies that are guaranteed renewable and for small group policies; 70 percent for group policies with 51-500 certificates; and 75 percent for group policies with greater than 500 certificates.

The rating law effectively prohibits insurers from establishing low premiums when a policy is first issued, with scheduled rate increases as the policyholder ages. Specifically, the law prohibits rating practices referred to as *durational rating*, *attained age premium structures* and *select and ultimate premium schedules* which classify insureds based on year of issue or duration since issue.

The Florida rating law restricts the ability of insurers to segregate policyholders into separate rating pools. The law attempts to prevent sharply escalating price increases, often referred to as "death spiral" rating. This occurs when an insurer stops selling a particular policy form and bases the premiums solely on the experience of those individuals covered under that particular form. As claims costs increase, premium rates increase. Healthy individuals are permitted to buy cheaper coverage under a new, similar policy form issued by the same insurer, but unhealthy individuals are denied new coverage. The claims experience worsens for the unhealthy individuals insured under the old policy form and, eventually, the rates become unaffordable. To prohibit such rating practices, the Florida law requires that the claims experience of all policy forms providing *similar benefits* be combined. If an insurer discontinues the availability of a policy form, the insurer may not file a new policy form providing similar benefits for at least 5 years, unless the department waives or lowers the 5-year prohibition.

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. An insurer may either make a full rate filing or file a certification that its rates are adequate and that a rate increase in not needed. One of the apparent purposes served by this law is to prevent an insurer from waiting multiple years to file a significant rate increase and to instead, have smaller, annual rate increases.

An insurer that issues individual health insurance policies is permitted to use a *loss ratio guarantee* as an alternative method of meeting rate filing and approval requirements. Under this procedure, the insurer guarantees that its policies will meet certain minimum loss ratios (that at least 65 percent of the premium will be paid in benefits, for example) and that it will pay refunds to its policyholders if the loss ratio is not met.

Insurers issuing out-of-state group policies may engage in rating practices that state law prohibits for policies issued directly in the state, except that the small group guaranteed-issue and community rating requirements apply to coverage sold to a small employer in Florida under an out-of-state trust or association policy. Functionally, this product is very similar to individual coverage. An individual contacting an insurance agent to purchase health insurance will often be offeredcoverage under an out-of-state group plan and the consumer is not likely to know the difference, even though the policy itself must contain disclosures that state law does not apply.

Health Insurance Issues Considered in 1999

During the 1999 legislative session, four bills making significant changes to the health insurance laws were considered and reported favorably as Committee Substitutes by the Senate Banking and Insurance Committee, but were not passed by the Legislature. The bills are summarized below, as passed by the committee:

CS/CS/SB 1294 – Employee Health Care Access Act (Small Group Coverage) — This bill would: (1) delete the requirement that small group carriers provide guaranteed-issue coverage year-round for employers with one employee, sole proprietors, and self-employed individuals and, instead, provide for a 31-day annual open enrollment period during the month of August; and (2) allow small group carriers to adjust a small employer's rate by 15 percent, based on health status, claims experience, or duration of coverage.

CS/SB 1556 – Health Alliance for Small Business (Restructuring CHPAs) — This bill would create the Health Alliance for Small Business, a nonprofit corporation, governed by a board composed of the chairs of the existing boards of the eight Community Health Purchasing Alliances (CHPAs). The stated purpose was to more effectively pool small employers into larger groups to facilitate a program of affordable group health insurance coverage. Instead of offering separate policies to employers and employees from all approved plans as currently required for CHPAS, the Alliance would be issued a master policy from insurers selected by the board as offering the most competitive products and prices, to which employees would be added as they enroll.

CS/SB 1576 – Health Insurance Rating Law — This bill would revise the health insurance rating laws to: (1) delete the standard for disapproving premium increases that are "not viable for the policyholder market"; (2) delete the authority of the department to determine whether rate increases are reasonable in relation to benefits and, instead, specify loss ratio requirements in the statute; (3) delete the requirement that an insurer combine the claims experience of all similar policy forms; (4) delete the prohibition against an insurer filing a new, similar policy form for at least 5 years after the insurer discontinues offering a policy form; and (5) exempt from rate regulation "unique" rate filings for group policies covering 51 or more persons.

CS/SB 1800 – Florida Health Endowment Association — This bill would replace the Florida Comprehensive Health Association with the newly created Florida Health Endowment Association (FHEA), a nonprofit entity which would provide insurance coverage to individuals whose health condition prevent them from obtaining coverage in the standard individual health insurance market. The bill appropriates $50 million from the General Revenue Fund to the Florida Health Endowment Trust Fund to fund the association.

METHODOLOGY

Staff reviewed the health insurance laws of fourteen other states and interviewed insurance regulators in those states in order to compare key features of Florida's laws. Interviews with representatives of insurers were also conducted. Insurance coverage data was obtained from the Employee Benefits Research Institute and the U.S. Census Bureau. Premium rate increases for individual, small group, and large group coverage in Florida were obtained from the Department of Insurance. Various published studies were analyzed that compared the effects of state health insurance reforms.

FINDINGS

Although the Florida Legislature has enacted several laws designed to increase the number of Floridians who have health insurance through an employer-based plan or through individual coverage, the uninsured rate in Florida has steadily increased from 21.8 percent in 1995 to 23.7 percent in 1997. The uninsured rate for the nonelderly has continued to climb in Florida and Florida's rate has remained well above the U.S. average for each of the last 3 years. Similarly, Florida has consistently had a lower percentage of persons with employer-based coverage as compared to the national average. Certainly, the uninsured rate in any state is dependent upon many factors other than the health

insurance laws, such as income level, employment rate, and other socioeconomic and demographic factors. However, as a broad measure, the uninsured rate is illustrative.

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, as of March 1999. Currently, 90 carriers are offering small group coverage, which reflects a fairly healthy market providing small employers with competitive products.

As of February 1999, 86,766 persons were insured through CHPAs, a further decline from the 94,090 persons who were insured through CHPAs in December 1998. This decline appears to be due to a large number of insurers and HMOs discontinuing their participation in CHPAs. Within the past year, 15 insurers and HMOs have either withdrawn or are in the process of withdrawing from participation in the CHPAs, leaving only 10 carriers remaining.

Coverage for large employers in Florida appears to be widely available and competitive. There is general agreement that large employer size and market competition help protect against rate increases. For employers with 500 or more employees, the carrier and the employer are likely to negotiate an experience rated policy, for which the employer's premiums are based primarily on its own loss experience. For such policies, it appears that the department performs a relatively cursory review of the rate filing which are rarely disapproved. Only three health insurers are believed to be actively issuing individual, in-state, major medical insurance policies in the state, the largest writer of which is Blue Cross & Blue Shield of Florida with 84,241 individual policies, followed by Mutual of Omaha Insurance Company with 6,056 policies, and Continental General Insurance Company with 3,916 individual policies. There are 11 health maintenance organizations that issue individual HMO contracts, but coverage is limited to certain geographical service areas.

The Florida rating law does not specifically address the extent to which a carrier may impose a premium surcharge for individual coverage based on health status. In practice, carriers writing individual coverage will have two or three rating categories for a *standard* risk and for one or two *nonstandard* risks. The department reports that nonstandard rates with surcharges as great as 150% above the standard rate have been approved. However, the experience of all persons insured under similar policy forms must be pooled together for rating purposes. The claims experience of all standard and nonstandard risks must be pooled together under each of these rating pools, so that all policyholders generally experience the same percentage rate changes.

The Department of Insurance has been engaged in a lengthy process of revising its health insurance rating rules, for which an administrative proceeding is still pending. One of the issues addressed in the proposed rules, not currently addressed, 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*. Another issue is a definition of *similar benefits* for purposes of the current law that requires insurers, for rating purposes, to combine the claims experience of all policy forms providing similar benefits.

Staff compared Florida's health insurance laws with the laws of fourteen other states, selecting the most populous states and those states which were known to have enacted health insurance reforms, which included: California, Colorado, Connecticut, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Oregon, Pennsylvania, and Texas.

Rate Filing Procedures— In all of the 15 states surveyed, some type of rate filing is required for individual health insurance policies. A file and use system is required by 8 states for individual and/or group filings. In general, these states allow rates to be charged without department approval, but the department typically has authority to intervene. Prior approval is used in 11 states for individual and/or group filings. However, states categorized as prior approval typically provide that rates are deemed approved after a certain time period, if the department does not act.

Georgia, Massachusetts, New Jersey, and Pennsylvania do not require a rate filing to be submitted for small group indemnity plans. However, at least nine states require some type of annual rate certification form to be filed. In Oregon, small groups rates for small employers (comprised of 2-25 employees) are regulated.

Rate Standards— Based on a review of rate regulations of other states and interviews with state regulators, many states have broad discretionary authority in the regulation of health insurance products in the

individual and group markets. Some states have codified language that rates may not be excessive, inadequate or unfairly discriminatory (Colorado, Kentucky, Indiana) In Indiana, New Jersey, as in Florida, benefits may not be unreasonable to premiums charged. In Pennsylvania, individual rates are also required to provide for internal equity.

Based on interviews with regulatory officials, many states have implemented specific, but often unwritten administrative guidelines to use for evaluating rate filings. For example, in Colorado, the small group rates are not generally reviewed unless an increase of 10 percent or more is requested. However, if the regulator receives a consumer complaint, a rate review could be triggered. In Georgia, rates for individual policies are primarily market driven and rates are reviewed using broad guidelines. Texas requires only an informational filing for individual rates.

Many states require carriers to meet minimum loss ratio standards, either by statute, rule, or by unwritten administrative guideline. Minnesota requires individual and small group carriers to meet certain loss ratio standard requirements. Generally, if a carrier holds less than 3 percent of the individual market share, the loss ratio is set at 68 percent or if a carrier holds 3 percent or more of the individual market share, the carrier is subject to 72 percent loss ratio. In the small group market, if a carrier holds less than 3 percent of the market share, the loss ratio is established at 75 percent. If a carrier holds greater than 3 percent of the market share, the loss ratio is set at 82 percent. In Connecticut, individual rates are not deemed excessive if the insurer meets certain loss ratios. The required minimum loss ratio for individual rate filings range from 60-65 percent.

In Indiana, New Jersey, as in Florida, benefits may not be unreasonable to premiums charged. Minimum loss ratios for individual policies in New Jersey are established in the 50 - 60 percent range, which is generally lower than Florida which imposes a 55 to 75 percent range. For New Jersey, the premium rate charged by a small employer carrier to the highest rated small group cannot be greater than 200 percent of the premium rate charged for the lowest rated small group.

In New York, small group (indemnity) rate filings are deemed approved if the loss ratio is at least 75 percent. New York requires a health maintenance organization to increase its rates if the loss ratio is greater than the maximum and the rate was the subject of a rate adjustment during the previous year. The premium rate increase must be in an amount sufficient to ensure that, when added to direct premiums earned for each contract form, a recalculation of the loss ratio of the previous calendar year will equal no more than 105 percent. For small group HMOs, a loss ratio of 75 percent is required. For individual, direct payment contracts, a loss ratio of 80 percent is required.

Large Group Regulation — Many states do not regulate rates for large groups (more than 50 employees). However, it was noted that if large groups were regulated by a particular state, typically the regulation was limited to health maintenance organizations and nonprofits (Blue Cross & Blue Shield).

The following states did not require rates for large groups (indemnity products) to be filed: California, Connecticut, Georgia, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, and Texas. In Indiana, large group carriers are required to file rates; however, the rates are not reviewed and the rates are market driven. In Massachusetts, only health maintenance organizations are subject to rate regulation in the large group market. In Minnesota, large group initial or renewal rates are not subject to approval. However, certain loss ratio standards apply to the large group. In Connecticut, indemnity group (small and large) rates are exempt from regulation; however, health maintenance organizations are required to obtain rate approval. Pennsylvania requires rate filings for health maintenance organizations and Blue Cross & Blue Shield; indemnity plans are exempt.

Small Group Sizes and Rating Factor — In 10 of the 15 states, a small employer is defined as an employer with 2-50 employees. However, five states defined small employer to include groups of 1 to 50 (Colorado, Connecticut, Florida, Massachusetts, and New York).

Ten of the 15 states allowed health factors to be considered for purposes of establishing small group rates. In these 10 states, the maximum percentage adjustment allowed ranged from 10 - 25 percent, except for Illinois which does not regulate small group rates and Oregon which does not regulate small groups with 26-50 employees. Five states do not allow the use of health factors (Connecticut, Florida, Massachusetts, New Jersey, and New York). Two states (Colorado and Pennsylvania) allow health factors to be used for a limited group. Colorado allows health factors to be used for groups of one and Pennsylvania requires community rating only for health maintenance

organizations and Blue Cross & Blue Shield plans with less than 25 employees.

Guaranteed Access to Individual Health Insurance Provisions — Four of the fifteen states reviewed have implemented guaranteed issue for individual coverage. Three of these four states require open enrollment year round; however, Massachusetts limits open enrollment to a 2-month period during the year. Eight of the states reviewed have a high-risk pool that offers coverage to persons otherwise unable to obtain coverage. Florida, Georgia, and Pennsylvania are the only three states that do not have either guaranteed issue or a high-risk pool for individual coverage.

RECOMMENDATIONS

It is recommended that the Legislature consider the following recommendations:

Small Group Coverage - To maintain access to coverage for one-life groups, but limit the effects of adverse enrollment which occurs when someone waits until a health problem occurs before obtaining coverage, an annual or semiannual enrollment period of 30 or 60 days should be considered.

In answering the question of the extent to which healthy risks should subsidize unhealthy risks, legislators should rely more on their own sense of fairness and equity than on an expectation that the percentage of insured small employers will significantly increase or decrease. Allowing insurers to increase or decrease a small employer's premium due to health factors by a limited amount, such as 10 or 15 percent, may make coverage more affordable for a small employer with healthy risks and provide an incentive to help control claims costs. However, this change is not likely to have a significant impact on the overall rate of employers obtaining coverage and comes at a cost to those employers with greater than average claims costs.

The CHPAs would have the opportunity to obtain greater savings for small employers if they were authorized to issued one master policy and had the ability to negotiate rates and benefits with selected carriers, subject to the same insurance laws that apply to other association groups. The law has never given CHPAs the ability to actually pool the bargaining power of a group of small employers, because coverage from all participating carriers must be offered to each small employer.

Rating Law - One feature of Florida's rating law that appears to be unusual is its prohibition on rate increases that are *not viable to the policyholder market*, which is a very broad standard. Revising this standard to be more specific would provide better guidance to insurers and the department.

Large Group Coverage - Deregulation of rates for coverage of large employers above a certain size, somewhere in the range of 100 to 500 employees, should be considered.

Individual Coverage - The Legislature should consider addressing the need of high-risk individuals seeking health insurance coverage. Florida is one of only three states, out of the fifteen surveyed, that did not have either a high-risk pool or guaranteed-issue of individual coverage for meeting this need. Guaranteed-issue has the advantages of integrating high-risk individuals into the same insurance pool as healthy risks, but at a cost of increasing rates for current policyholders, depending on the extent to which carriers may impose surcharges due to health factors. A high-risk pool appears to be less disruptive to the private individual market, but deficits funded by assessments against insurers similarly adds costs to other policyholders, which can only be avoided by public funding of deficits.

Out-of-state coverage - Functionally, selling coverage to individuals in Florida under an out-of-state group policy is the same as selling an individual policy, and there does not appear to be any policy reason for different rate requirements. The Legislature should consider applying the same rating laws that apply to individual coverage to out-of-state policies covering individuals in Florida.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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MEMBER OVERSIGHT
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