

Analysis of the Current Health Insurance Market in Florida

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Background

Overview of Current Health Insurance Market in Florida

Over the past decade, many federal and state initiatives have been enacted to increase access for groups, as well as individuals, to health insurance coverage.¹ Most states, including Florida, have enacted health insurance reforms that guaranteed access to coverage for certain categories of persons, limited the use of health status as a factor in calculating rates, and protected individuals from losing coverage for preexisting health conditions when changing health plans. These types of reforms were designed to encourage the continued participation in the voluntary private health care system by those not eligible for various publically funded health care programs such as Medicaid, Medicare, or subsidized health insurance programs for children of low-income families.² By requiring private health insurers to guarantee-issue coverage³ and to use some form of community rating to spread the costs of unhealthy insureds over a large number of policyholders, lawmakers have attempted to modify private market behavior that would otherwise avoid high-risk policyholders or charge rates that would discourage broader coverage.

Due in part to our economic reliance on small businesses, Florida has been among the more reform-minded states when developing measures to assist small groups in obtaining health insurance. Florida law requires insurance carriers to guarantee-issue coverage to all small employers with one to fifty employees regardless of their health condition, and to allow limited use of health status, claims experience, or duration of coverage in adjusting a small employer's premiums.⁴

¹ Many of these reforms are summarized in three reports issued by the Florida Senate Banking and Insurance Committee: *Access to Health Insurance Coverage*, Report 1997-P-25; *Rating Practices of Insurers Issuing Health Insurance Policies and Certificates to Individuals who are Eligible for Guaranteed-Issuance of Coverage*, Report 1998-05, and *Review of Florida's Health Insurance Laws Relating to Rates and Access to Coverage*, Report 2000-04.

² Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Medicare is a federally administered health insurance program that covers the costs of hospitalization, medical care and some related services for eligible persons. Medicare has two parts: Part A covers inpatient costs while Part B covers outpatient costs.

³ "Guarantee-issue coverage" means an insurance policy that must be offered to an employer, employee or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

⁴ In contrast, Florida law does not require guarantee-issuance of individual coverage unless the individual had coverage within the prior 63 days.

In contrast to the laws passed to assist small businesses, Florida has been less reform-minded with respect to individual coverage, perhaps because of the availability of coverage for one-person businesses.⁵ Apart from the self-employed, for the most part individuals in Florida do not have access to guaranteed coverage, either through a private insurer or, as many states provide, through a high risk pool.⁶

Rates for individual and group coverage must be filed by insurers and health maintenance organizations (HMOs) for approval with the Department of Insurance at least 30 days prior to use.⁷ General statutory rate standards require rates to be reasonable in relation to benefits and prohibit rate increases that are not viable to the policyholder market. The law also prohibits specific rating practices, generally intended to prevent steep rate increases in later years. Department rules establish minimum loss ratios, which set the minimum percentage of the premiums that must be paid in benefits.

Although not guarantee issue, coverage for large employers (over 50 employees) in Florida is generally available, except for smaller large groups having exceptionally poor claims history or health status. While groups in this category may have difficulty obtaining coverage bids, there is general agreement that the employers in the large group market have a number of options for coverage and sufficient competition to help mitigate rate increases.

Florida law exempts “out-of-state group” policies from rate filing and approval regulations. This is a hybrid form of coverage that, while possessing some aspects of group structure, is essentially marketed to individuals in Florida through memberships in associations or trusts located in other states. Florida law allows such coverage provided to Floridians to be governed by the insurance laws of the states where the associations or trusts are located, enabling insurers issuing such coverage to engage in rating practices that Florida law prohibits for individual policies issued directly to citizens in the state.⁸

During the 2001 session a number of major health insurance issues were considered but not passed, including the Governor’s proposal to allow for the sale

⁵ “One-person businesses” or one-life groups are sole proprietors or self-employed individuals who are guaranteed the issuance of health insurance coverage regardless of health status, preexisting conditions, or claims history. However, such guaranteed coverage is available only during the annual open enrollment period for such persons, during the month of August.

⁶ However, Florida law does provide that a person who loses eligibility for individual coverage qualifies for new individual coverage, if the person’s prior coverage was terminated for specified reasons.

⁷ Insurers must file their rates pursuant to s. 627.410, F.S., while the rating requirements for HMOs are under s. 641.31, F.S.

⁸ However, the small group guarantee-issue and modified community rating requirements apply to coverage sold to a small employer in Florida under an out-of-state trust or association policy.

of “health-flex” plans in areas with the highest rates of uninsured, broader authority for insurers to sell limited benefit plans, re-opening the Florida Comprehensive Health Association to sell health insurance to persons unable to obtain coverage due to their health status, revising the standards for regulating health insurance rates, and applying rating laws to certain out-of-state group policies. These issues are expected to be addressed again during the 2002 session.

In an effort to gauge the impact of these recent legislative proposals in light of the health insurance provisions noted above, it would be beneficial to have additional information and a better understanding of the current status of the health insurance market in Florida. Therefore, this report will highlight the most recent health insurance information obtained by the Department of Insurance during a recent “data call” to insurers which features the three primary markets in Florida: the individual, small group and large group markets. The report will also review the current health insurance provisions in Florida and will summarize key findings contained in the 1999 Florida Health Insurance Study (FHIS) on the uninsured which was conducted by the University of Florida for the Agency for Health Care Administration.

Current Law

Individual Coverage

No Guarantee-Issue or High-Risk Pool --- Florida law does not guarantee that all individuals have access to a health insurance policy. Insurers are generally free to determine whether to issue coverage to an individual based on their health status. However, from 1983 until July 1, 1991, persons who could not obtain health insurance coverage due to their health status were eligible to buy coverage from the Florida Comprehensive Health Association (FCHA), a state-created insurer.⁹ The FCHA was funded by policyholder premiums capped at 250 percent of the standard risk rate for individual coverage and by assessments levied against insurance companies writing health insurance in Florida. 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. Currently, 709 individuals remain insured with the FCHA with the average annual premiums per policyholder at \$3,400.¹⁰ The current net loss to be assessed for calendar year 2000 is \$5.4 million on a base of \$11.5 billion.

Guaranteed Renewability--- Florida and federal law require that individual health insurance policies and individual HMO contracts be guaranteed renewable, subject to certain exceptions. By way of background, in 1996, Congress enacted

⁹ S. 627.6488, F.S.

¹⁰ Data for calendar year 2000, from the FCHA Summary of Plan Activities 2000, issued October 1, 2001.

the Health Insurance Portability and Accountability Act (HIPAA), which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and met other eligibility criteria. HIPAA allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. The act also allows each state to craft alternative methods of guaranteeing availability of coverage.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA).¹¹ To be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a group plan, a governmental plan, or church plan. However, in 1998, Florida expanded the eligibility criteria under state law to also include persons whose most recent coverage was under an *individual* plan if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO.¹² Legislation in 2000 limited this provision to prior individual coverage issued in Florida.¹³

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. These mechanisms apply after exhaustion of the period of time that group coverage can be continued under the federal COBRA law or Florida's "mini-COBRA" law, which, generally, is up to 18 months.¹⁴ One method requires the insurance company or health maintenance organization (HMO) that issued the group health plan to offer an individual conversion policy to persons who lose their eligibility for group coverage. At least two conversion policy options must be offered, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. Florida's second method of guaranteeing access to individual coverage is allowing eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. The policy must be offered on a guaranteed-issue basis, regardless of the health condition of the individual. The insurer or HMO must offer each of their

¹¹ Ch. 97-179, L.O.F., creating s. 627.6487, F.S.

¹² Ch. 98-159, L.O.F.

¹³ Ch. 2000-365, L.O.F.

¹⁴ The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to employers with 20 or more employees and allows individuals who lose eligibility for group coverage to continue their coverage for 18 months by paying up to 102 percent of the group premium. The Florida Health Insurance Coverage Continuation Act, s. 627.6692, F.S., ("mini-COBRA") applies to insurers covering employers with fewer than 20 employees, and allows continuation for 18 months at 115 percent of the group premium.

two most popular policy forms, based on statewide premium volume. This method applies to eligible persons who are not entitled to a conversion policy under ss. 627.6675 or 641.3921, F.S. This generally includes persons who were previously covered under a self-insured employer's plan or who move out of the service area of an HMO.

According to the Department of Insurance (DOI), the requirement for individual health insurance carriers to offer their two most popular policy forms to HIPAA-eligible individuals has resulted in carriers reducing the benefits available under their most popular policies. For example, maternity coverage is commonly excluded from carriers' two most popular policy forms.

The DOI interprets the current law as prohibiting an individual carrier from discriminating against HIPAA-eligible individuals in the premium rates charged. Under this interpretation, a carrier is permitted to surcharge a HIPAA-eligible individual based on health status, as long as the carrier imposes the same surcharge on non-HIPAA-eligible persons applying for coverage.

Small Group Coverage

Guaranteed-Issuance of Coverage and Modified Community Rating¹⁵---In 1992, the Florida Legislature created the Employee Health Care Access Act (Act)¹⁶ which required insurance companies in the small group market to guarantee the issue of coverage to any small employer that applied for coverage regardless of the health condition of the employees.¹⁷ In 1993, the Act was expanded to cover employers with 1 to 50 employees, including sole proprietors and self-employed individuals¹⁸

Legislation in 2000 limited the guaranteed-issue provisions of the Act by providing that employers with fewer than two employees, typically referred to as "one-life groups," are limited to a one-month open enrollment period in August of each year, rather than the year-round guarantee-issue requirement that previously applied, and that continues to apply to employers with 2-50 employees.¹⁹ The

¹⁵ In general, "community rating" is a method of developing health insurance rates which takes into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are not considered. Florida utilizes a variation on this method, "modified community rating," which allows carriers to consider a limited set of individual characteristics relating to the individuals actually covered. Under the 1992 Act, these factors included age, gender, family composition, tobacco usage, and geographic location. Legislation enacted in 2000 revised the "modified community rating" component to permit small employer carriers to adjust premium rates based on additional factors such as employees' claims experience, health status or duration of coverage.

¹⁶ S. 627.6699, F.S.

¹⁷ Ch. 92-33, L.O.F.

¹⁸ Ch. 93-129, L.O.F.

¹⁹ Chapters 2000-256 and 2000-296, L.O.F.

2000 law also changed the requirements for "modified community rating," which previously prohibited insurers from considering health status or claims experience in establishing premiums, and allowed only age, gender, geographic location, tobacco usage, and family size to be used as rating factors. As amended, the law now allows small group carriers to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these factors.²⁰

Carriers have consistently reported that their claims experience for one-life groups is much worse than for larger size employers. The DOI, as an example, stated that some carriers reported a loss ratio of about 135 percent for one-life groups, meaning that for every one dollar of premium, the insurer pays \$1.35 in benefits.

Small group carriers are required to offer a *standard health benefit plan* and the *basic health benefit plan* to each small employer applying for coverage. The Act lists certain benefits that must be included in each of these policies. The Act also authorized the appointment of a health benefit plan committee to recommend to the DOI additional provisions for the plans which were incorporated into the standard and basic policies. In addition, a *limited benefit policy* or contract may be offered by a small employer carrier, which is a policy or contract providing coverage for named insureds for a specific named disease, accident, or limited market such as the small group market. Small employer carriers offering coverage under limited benefit policies or contracts must make certain disclosures to small employer groups including, explaining those mandated benefits and providers that are not covered under the policy or contract; explaining the managed care and cost control features of the policy or contract; and explaining the primary and preventative care features of the policy or contract.

The Act provides that the standard, basic, and limited benefit plans are exempt from any law requiring coverage for a specific health care service or benefit, e.g., "mandated health benefits,"²¹ or any law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, unless that law is made expressly applicable to such policies or contracts.²²

²⁰ Rate adjustments made pursuant to these factors are subject to the following limitations:

a) Per employer: up to 15% deviation from carrier's approved rate; up to 10% change annually on renewal; and it must be applied uniformly to all employees and dependents;

b) All employers: up to 5% deviation (in the aggregate) from carrier's approved rate.

Small employer carriers are also permitted to credit a small employer's premiums based on certain administrative and acquisition expense savings realized by the carrier. Further, instead of being required to use one rating category for all dependent children, small employer carriers are permitted to use rating methodologies that include up to three separate rating categories for one, two, and three or more dependent children.

²¹ "Mandated health benefits" are laws which require private insurers and HMO health plans to provide for certain coverages.

²² S. 627.6699(15), F.S.

Large Group Coverage

No Guarantee Issue of Coverage--- The is no guarantee issue of coverage to large groups (more than 50 employees), however, like all groups, coverage is renewable at the option of the policyholder. According to the DOI, coverage for large employers in Florida appears to be widely available. There is general agreement that large employer size and market competition help protect against rate increases and diminish the need for state regulation to protect consumers.

Any problems that do exist in the large group market are generally reflected in the smaller large group market of approximately 50 to 125 employees, where several very bad claims can easily affect a group's desirability to insurers. Offers to such groups may be few and premiums would therefore be high.

Large employers face another choice small employers do not have which is whether to purchase insurance or be self-insured. For example, some employers with as few as 25 employees may self-insure, that is to pay for their employees claims out of company assets and purchase a "stop loss" policy.²³ Often it is a matter of each employer's risk tolerance or an assessment of potential exposure as to whether or not to self-insure.

Out-of-State Group Policies

Limited Florida Regulation of Out-of-State Group Policies---Insurers that issue policies to groups or associations outside of Florida, but which are sold and marketed to individuals in Florida (who are issued "certificates"), are generally exempt from Florida's rate filing and approval requirements. This insurance, commonly referred to as "out-of-state group," is typically sold under a group master policy issued to an association or a trust formed outside of the state. Coverage under the policy is then delivered to individuals in Florida who join the association as members, to Florida employers who join the trust or to Florida employees of such employers. Certificates evidencing this coverage are exempt from many of the laws that apply to insurance companies that sell group or individual health insurance directly in the state. As a result, no effective rate or underwriting requirements apply to these out-of-state group policies.

Florida law does require that the group certificates issued in Florida be filed with the DOI "for information purposes only."²⁴ The law further provides that if the

²³ Stop loss insurance is oftentimes taken out by a self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year. There are two main types of stop loss insurance: 1) *specific or individual*: reimbursement is given for claims on any covered individual that exceed a predetermined deductible; and 2) *aggregate*: reimbursement is given for claims that in total exceed a predetermined level, such as 125 percent of the amount expected in an average year.

²⁴ S. 627.410(1), F.S.

group is established primarily for the purpose of providing insurance, the benefits must be reasonable in relation to the premiums charged.²⁵ Even though this provision provides the DOI with some authority to determine whether rates are reasonable, this has not proven to be effective due to: 1) the lack of any rate filing requirement, 2) the fact that specific rating laws, such as those designed to prohibit “death spiral”²⁶ rating practices, do not apply to out-of-state group policies, and 3) the difficulty of proving that a group has been formed primarily for insurance purposes when the group has established other paper credentials as to some other purpose.

The DOI reports that it has received many complaints from Florida residents covered under out-of-state group policies relative to the “death spiral” rating practices that are prohibited under policies issued in Florida. In the past several months, the DOI has identified five insurance companies and eight HMOs that currently issue individual policies in Florida, as compared to 15 insurance companies that market individual coverage in Florida through out-of-state associations.

However, the requirements of the laws that apply to policies issued to small employers, summarized above, apply to out-of-state associations covering a small employer in Florida. Also, Florida laws for Medicare supplement policies apply Florida's rating laws to certificates covering Florida residents under an out-of-state group policy.²⁷ Similarly, for long-term care policies, the current law provides that coverage may not be issued in Florida under a group policy issued to an association in another state, unless Florida or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Florida, has made a determination that such requirements have been met. Evidence to this effect must be filed by the insurer subject to the procedures specified in s. 627.410, F.S.

Prior to solicitation in Florida of out-of-state group coverage, a copy of the master policy and a copy of the form of the certificate that will be issued to Florida

²⁵ S. 627.6515(2)(a), F.S.

²⁶ Certain rating laws are designed to prohibit so-called “death spiral” rating practices. This is the practice where an insurer stops selling a policy form and bases rates solely on the experience of the individuals covered under the form. As claims and the rates for the group increase, healthy individuals are able to meet underwriting standards to buy a new policy issued by the same insurer. But, unhealthy individuals are denied new coverage and the rates under the old policy continue to escalate due to the declining pool of insureds and worsening claims experience. Eventually the rates become unaffordable. The practice is then repeated with the new policy form. To prevent such death spiral rating practices, the Florida law requires that the claims experience of all policy forms providing similar benefits be combined (or “pooled”) for all rating purposes. An insurer must provide 30 days notice to the department prior to discontinuing the availability of a policy form, and the insurer is prohibited from filing a new policy form providing similar benefits for at least 5 years, subject to a shorter period approved by the department (s. 627.410(6)(d)-(e), F.S.).

²⁷ Sections 627.672 and 627.6745, F.S.

residents must be filed with the DOI for informational purposes. The certificates must contain the following statement: “The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.” Out-of-state group policies are subject to some, but not all, of the statutorily mandated benefits,²⁸ but the level of enforcement of such requirements is much less than for in-state policies due to the absence of any requirement for filing policy forms with the DOI for approval.

Florida law currently treats out-of-state group insurers the same as an insurer issuing individual policies in one important respect. Florida’s HIPAA-conforming legislation requires individual health insurance carriers to guarantee-issue coverage to HIPAA-eligible individuals who are not eligible for a conversion policy. This requirement applies to carriers issuing certificates to Florida residents under a group policy issued to an association outside of Florida, as well as carriers issuing individual policies in Florida.²⁹

Health Insurance Issues Considered in 2001

During the 2001 session, several bills making significant changes to the insurance laws were considered and reported favorably by the Senate Banking and Insurance Committee, but were not passed by the Legislature. The legislation, which was consolidated into a omnibus health insurance package, is summarized below as it passed the Senate.

Senate amendment (800658) to CS/HB 1253 (substituted for CS/SB 1960 and 1760 by Senate Banking and Insurance Committee and Senators Latvala and King), provided for the following:

- **Health Flex Plans:** created a pilot program to provide health care coverage for uninsured, low-income persons, referred to as health flex plans. The Agency for Health Care Administration and the Department of Insurance would approve health flex plans in the three areas of the state having the highest number of uninsured residents, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. Such plans would be exempt from the requirements of the Insurance Code.
- **Limited Benefit Policies:** expanded the definition of a “limited benefit policy or contract” that could be offered to either small or large employers that would be exempt from mandatory benefits that normally apply to health insurance policies or HMO contracts. Such policies would be prohibited from discriminating against any health care provider.
- **Out-of-state group policies:** required that the certificate of coverage issued to a resident in Florida under a group policy issued outside of Florida be subject to the same requirements of the Insurance Code that apply to individual health insurance policies issued in Florida, if the

²⁸ As specified in s. 627.6515(2)(c), F.S.

²⁹ S. 627.6487(2)(b), F.S.

insurer requires individual underwriting to determine coverage eligibility or premium rates to be charged to the Florida resident.

- **Large Groups:** exempted from rate filing requirements group health insurance policies and HMO contracts insuring groups of 51 or more persons, with certain exceptions.
- **Rates:** exempted from annual rate filing requirements insurance policy forms with fewer than 1,000 nationwide policyholders or members and allows for an annual rate increase limited to medical trend. Established specific actuarial criteria for rate disapproval and provided that prior approval is not required if rate filings meet certain criteria: (a) the insurer has complied with annual rate filing requirements for the 2 previous years; (b) the insurer has pooled the experience of all policy forms providing similar benefits; and (c) the rates are anticipated to meet a minimum loss ratio of 65 percent.
- **Individual Coverage:** allowed carriers writing individual policies to offer “HIPAA-eligible” individuals the standard and basic policy that small group carriers are required to offer, as an option to offering the insurer’s two most popular policy forms. The bill also prohibited individual carriers from applying discriminatory underwriting and rating practices to HIPAA-eligible individuals.
- **Small Group Coverage:** allowed small group carriers to separate the experience of their insured one-life groups into a separate rating pool. But, the rate for one-life groups could not exceed 150 percent of the rate for groups of 2-50 employees. The bill also provides that small group carriers may only provide credits (not surcharges) due to duration of coverage.
- **Long-Term Care Insurance:** authorized the DOI to adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners. The provisions are designed to prevent insurers from implementing large rate increases after a policy has been issued.
- **FCHA:** re-opens the Florida Comprehensive Health Association for enrollment on January 1, 2002, with coverage to be effective on or after April 1, 2002; funding is provided by a \$10 million appropriation contingent upon the passage of CS/CS/SB 2214 which provided this appropriation from the tobacco equity surcharge; capped new enrollment at 500 persons for calendar year 2002 and allowed for additional 1,500 persons, effective January 1, 2003, (for a total cap of 2,000); required that premiums be based on an individual’s income. The premium rate would be 150 percent of the standard risk rate for persons at or below 200 percent of the federal poverty level, 250 percent of the standard risk rate for persons between 200 percent and 300 percent of the federal poverty level, or 300 percent of the standard risk rate for persons over 300 percent of the federal poverty level.

Methodology

In response to a committee staff request, the Florida Department of Insurance (DOI) initiated a special “data call” to over 1200 insurance companies and health maintenance organizations (HMOs) to provide health insurance premium and enrollment information for individual, small group and large group coverages.³⁰ The data obtained and compiled by DOI staff is the primary source of information utilized for the findings section of this report. Committee staff also obtained background information from insurance carriers, the U.S. Census Bureau, the Agency for Health Care Administration, and other independent studies. Staff also researched the health insurance laws in Florida.

Findings

During the 2001 interim, the Department of Insurance (DOI) requested health insurance data from 1,254 carriers representing all lines of insurance in order to provide the Legislature with a more complete overview of the commercial health insurance market in Florida than was previously available. In the DOI survey, the health insurance market was segmented into three categories: individual, small group and large group coverages. The individual and small group markets were further broken down as follows: the individual market was divided into in-state vs. out-of-state groups as well as HIPAA (Health Insurance Portability and Accountability Act) eligible guaranteed issue policies vs. policies written after health underwriting; the small group market was subdivided into one-life groups vs. groups of 2-50 employees. Also, carriers providing Stop Loss protection and/or carriers providing Administrative Service Only (ASO) were also included.³¹

Eighty nine percent of the 1,254 carriers responded, i.e., 1,112, of which 636 of these providers have authority to market general health and accident coverages or health maintenance organization services in the state. Ultimately, 189 carriers contributed applicable premium and enrollment information about the targeted health insurance products and services which is utilized as the basis for the primary findings for this report.³²

³⁰ Committee staff would like to gratefully acknowledge and thank Rich Robleto and Belynda Shadoan with the DOI who worked extremely hard in obtaining and compiling this health insurance information.

³¹ “Stop loss” coverage is defined in s. 627.6482(14), F.S. as an arrangement whereby a self-insurance plan insures against the risk that any one claim will exceed a specific dollar amount or that an entire self-insurance plan’s losses will exceed a specific amount. “Administrative services only” generally means a company which processes insurance claims, but does not insure the claims.

³² In the data call, the term “health insurance” was defined as any hospital and medical expense incurred policy, minimum premium plan, stop-loss coverage, health maintenance organization contract, prepaid health clinic contract, multiple-employer welfare arrangement contract, or fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract. The respondents were specifically requested to

2000 U.S. Census Data for Florida

In Table 1 below, the U.S. Department of Labor (DOL) has provided 2000 Census information about health insurance coverages for Florida.³³ This information provides a reasonable framework for viewing the general Florida market, however, it does not adequately furnish a thorough analysis of Florida's individual, small group and large group markets as does the information featured in the DOI tables below.

Table 1
U.S. Census Data for Florida-2000

Total Florida Population	15,052,000
Total Insured³⁴	12,159,000 (81%)
Total Uninsured	2,893,000 (19%)
Medicare	2,728,000 (18%)
Medicaid	1,265,000 (8%)

Florida's Uninsured-Findings from the Florida Health Insurance Study

In 1998, the Florida Legislature funded a study which examined the uninsured in Florida and was conducted by the University of Florida for the Agency for Health Care Administration. Key findings contained in the 1999 study, entitled the Florida Health Insurance Study, are highlighted below and featured in the three charts that follow.³⁵

- 2.1 million uninsured Floridians under age 65 (16.8 percent)*
- Over 500,000 uninsured children (age under 19)

not include coverage for Medicare supplement, accident, disability income, dental, vision, long term care, limited benefits, specified disease or illness, hospital indemnity or other fixed indemnity insurance coverages. Any coverages provided through governmental programs such as Medicare+Choice or the Florida Kidcare program (Healthy Kids) were also excluded. This decision was made, in part, due to the ready accessibility of information on the Medicare Supplement and Long Term Care Markets through the National Association of Insurance Commissioners (NAIC). Thus, the DOI data also includes information obtained from the NAIC's databases to identify the number of Florida Medicare enrollees who also have a Medicare Supplement contract and the number of Floridians who have a Long Term Care Policy.

³³ Census information is data which is "self-reported" which means that individuals report information on forms mailed to households by the U.S. Department of Labor.

³⁴ This represents individuals covered by private and governmental insurance.

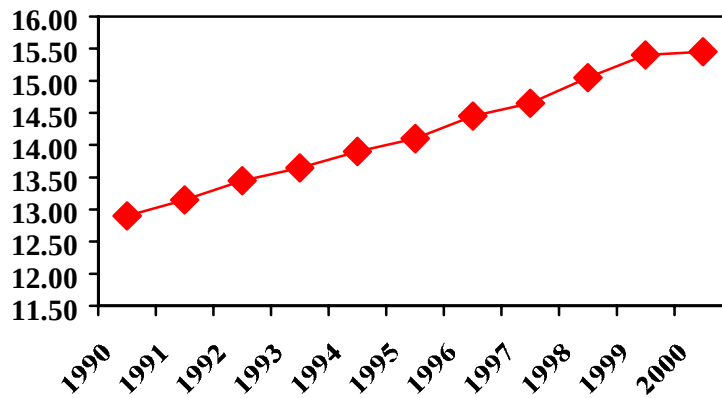
³⁵ The FHIS involved extensive data interpretation and interviews with 14,000 households representing more than 37,000 persons.

- About 58 percent of the uninsured earn less than 200 percent of the Federal Poverty Level
- Over 65 percent of uninsured employed Floridians have employers who do not offer health insurance
- Firms with less than 10 employees have a rate of uninsurance nearly three times the rate of firms with 50-99 employees
- Hispanics comprise nearly 25 percent of Florida's uninsured
- Most uninsured cite affordability as the main reason for not having health insurance

As Table 2 below indicates, while Florida's population has increased steadily throughout the 1990's, the number of uninsured Floridians has fallen from 2.6 million or 18.5 percent of the population in 1993 to 2.1 million or 16.8 percent of the population in 1999. (This uninsured rate is lower than the 19 percent rate reflected by the 2000 U.S. Census data shown above in Table 1.)

TABLE 2
While Florida's Population Has Increased,
The Number of Uninsured Has Decreased by
20 Percent Since 1993

Number of Floridians (In Millions)



Number of Uninsured Floridians
Under Age 65 (Millions)

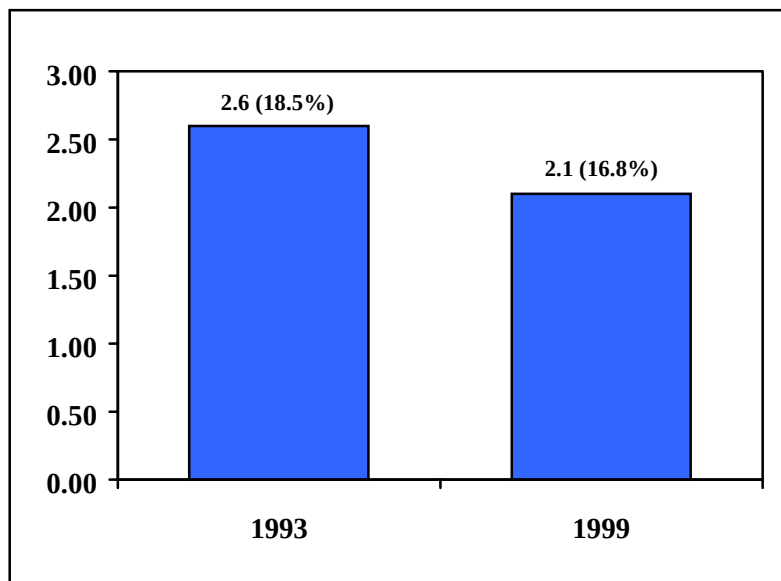
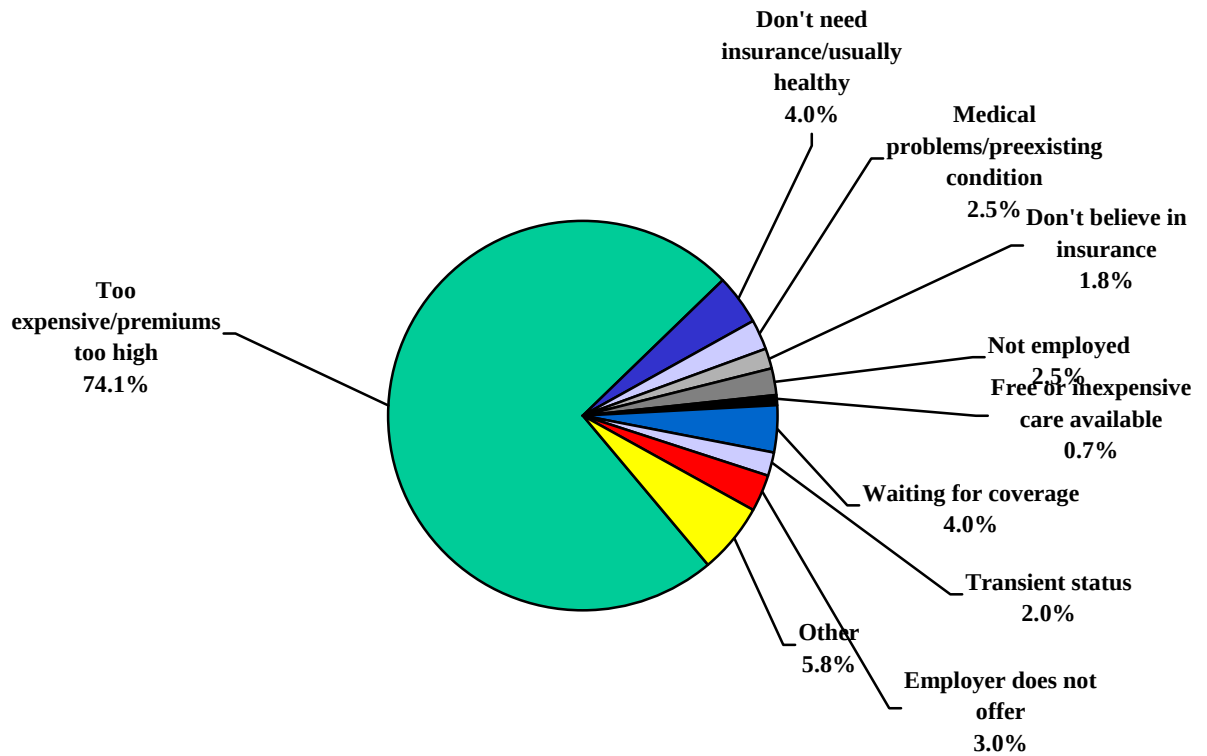


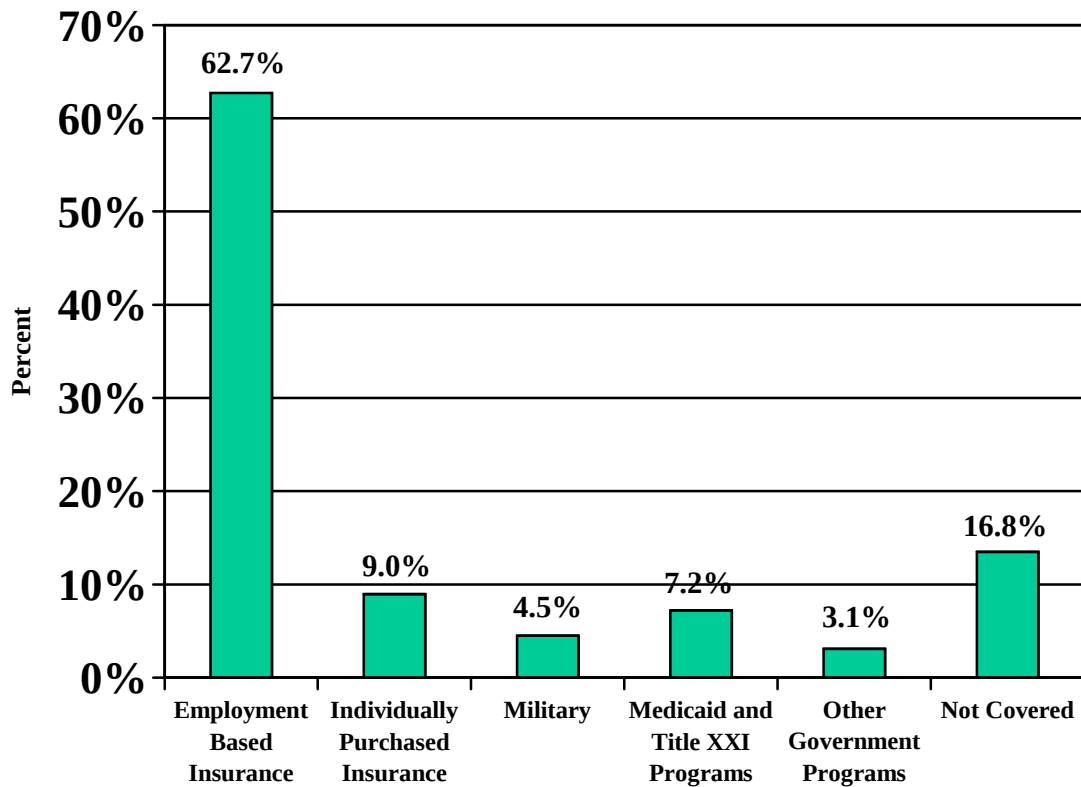
TABLE 3
"Too Expensive" - Main Reason Floridians 65 and Under Do Not Have Health Insurance



As indicated above in Table 3, by far the most commonly cited answer to the question, "What is the main reason that you do not have health insurance?" was "Too expensive/can't afford it/premiums too high." Fully 74.1 percent of respondents cited this reason for not having health insurance. By contrast, only 4.0 percent of respondents indicated that they "Don't need health insurance/usually healthy" and 2.5 percent cited "Medical problems/pre-existing conditions" as the main reason for their lack of health insurance. Those individuals who responded "Other" were allowed to specify their preferred answer. This resulted in 3.0 percent of respondents indicating that the main reason that they do not have health insurance was that their employer did not offer health insurance.

The following table (Table 4) shows Floridians with health insurance by source.

TABLE 4
FLORIDIANS UNDER AGE 65 BY SOURCE OF HEALTH INSURANCE



As Table 4 above indicates:

- 62.7 percent of Floridians report that they have health insurance coverage through a current or former employer or union (other than the military).
- 9.0 percent of Floridians report that they have health insurance coverage purchased on their own and not through an employer or union.
- 4.5 percent of Floridians report that they have health insurance through CHAMPUS, CHAMPVA, TRICARE, VA or some other type of military insurance.
- 7.2 percent of Floridians report that they are insured through Medicaid or Title XXI programs (Florida KidCare).
- 3.1 percent of Floridians report that they are insured through other government programs (e.g., Children's Medical Services and Medicare for the disabled and end-stage renal disease populations).
- 16.8 percent of Floridians report that they are not covered by health insurance.
- Employment-based health insurance coverage (current or former employer or union) for individuals ranges from a high of 70.7 percent in District 6 (Lake, Osceola, and Seminole counties) to a low of 53.4 percent in District 13 (De Soto, Glades, Hardee, Hendry, Highlands, Monroe, and Okeechobee counties).³⁶

³⁶ These are AHCA district designations.

- Reported Medicaid and Title XXI coverage rates (as a percent of the population under age 65) range from a low of 4.4 percent of individuals in District 7 (Orange County) to a high of 11.5 percent of individuals in District 2 (small northern rural counties.)
- Sources of health insurance are not mutually exclusive as to the AHCA survey. Some people have more than one type of coverage. Medicaid-related programs include Medipass, Medikids and Healthy Kids. Other government programs include Children's Medical Service and Medicare for the disabled and those with end-stage renal disease.

Survey of Health Insurers by the Department of Insurance

The information contained in the special data call by the DOI is featured in the following tables. In Table 5 below, carriers were asked to report total premiums and the number of persons covered in Florida for the following health insurance categories: individual market, small group market (1-50 employees), large group market, stop-loss coverage for self-insured employers, and administrative services only (ASO) for self-insured employers. (See Appendix B for the data call sent to all licensed carriers and for the definitions of the terms used.) The ASO data does not include non-insurance carriers that provide administrative services for a self-insured employer.

As shown in Table 5, the largest sector is the large group market, for which 75 carriers report a total premium of \$5.55 billion, insuring nearly 3.2 million persons in Florida. In addition, 71 carriers wrote \$1.56 billion of stop loss coverage for self-insured plans covering 1.32 million persons and 14 carriers provided ASO for plans covering over 2 million persons with a total premium of \$2.22 billion. In all, these large employer plans insure or self-insure about 6.5 million Floridians.

In the small group market, 65 carriers insure 1.34 million Floridians, which is about one-fifth of the persons covered in large group market (including self-insured plans). The total small group premium for 2000 was about \$2.45 billion. The smallest segment is the individual market, for which 102 carriers reported 600,510 persons covered in Florida, at a total premium of \$761.3 million.

For all categories combined, carriers reported a total premium of over \$12.5 billion, insuring or self-insuring 8,491,990 persons in Florida. Excluding stop loss and ASO plans for self-insurers, health insurance plans cover 5,140,693 Floridians, which is only 34.2 percent of the population.

Table 5
Summary by Reported Premium and Covered Lives
Calendar Year 2000

		PREMIUM EARNED		COVERED LIVES	
		premium	% of total	total	% of total
Individual Market – 102 carriers reporting participation					
Instate					
guarantee issue (HIPAA) – 14 carriers reporting		\$17,470,714	2.29%	12,220	2.03%
individually underwritten – 82 carriers reporting		\$527,843,725	69.33%	423,881	70.59%
instate total – 84 carriers reporting		\$545,314,439	71.62%	436,101	72.62%
Out of State					
guarantee issue (HIPAA) – 8 carriers reporting		\$2,205,359	0.29%	1,119	0.19%
individually underwritten – 30 carriers reporting		\$213,833,433	28.09%	163,290	27.19%
out of state total – 31 carriers reporting		\$216,038,792	28.38%	164,409	27.38%
Combined					
guarantee issue (HIPAA) – 21 carriers reporting		\$19,676,073	2.58%	13,339	2.22%
individually underwritten – 100 carriers reporting		\$741,677,158	97.42%	587,171	97.78%
combined total – 102 carriers reporting		\$761,353,231	100.00%	600,510	100.00%
Small Group Market – 65 carriers reporting participation					
Instate					
small group (one-life) - 31 carriers reporting		\$227,695,623	9.23%	97,013	7.22%
small group (2-50) – 54 carriers reporting		\$2,096,276,759	84.98%	1,181,229	87.90%
instate total – 55 carriers reporting		\$2,323,972,382	94.21%	1,278,242	95.12%
Out of State					
small group (one-life) - 8 carriers reporting		\$10,911,880	0.44%	4,630	0.34%
small group (2-50) – 20 carriers reporting		\$131,931,141	5.35%	60,907	4.53%
out of state total – 20 carriers reporting		\$142,843,021	5.79%	65,537	4.88%
Combined					
small group (one-life) – 35 carriers reporting		\$238,607,503	9.67%	101,643	7.56%
small group (2-50) – 64 carriers reporting		\$2,228,207,900	90.33%	1,242,136	92.44%
combined total – 65 carriers reporting		\$2,446,815,403	100.00%	1,343,779	100.00%
Large Group Market – 75 carriers reporting participation					
Instate					
instate total – 56 carriers reporting		\$5,265,524,286	94.87%	3,040,430	95.12%
Out of State					
out of state total – 35 carriers reporting		\$284,476,048	5.13%	155,974	4.88%
Combined					
combined total – 75 carriers reporting		\$5,550,000,334	100.00%	3,196,404	100.00%
Stop Loss Coverage – 71 carriers reporting participation					
Total		\$1,556,451,863	100.00%	1,320,445	100.00%
Administrative Services Only (ASO) – 14 carriers reporting participation					
Total		\$2,225,348,323	100.00%	2,030,852	100.00%
Total of All Categories – 189 carriers reporting		\$12,539,969,154	100.00%	8,491,990	100.00%

Table 6 below reflects the number and percentage of persons enrolled in health maintenance organizations (HMOs) compared to persons enrolled in a non-HMO health insurance plan, for each of the three markets. HMO coverage dominates in the large group and small group market. About 70 percent of persons enrolled in the large group market are covered by HMOs, while 65 percent of persons enrolled in the small group market have HMO coverage. However, in the individual market, only 33 percent of persons are covered by HMOs, compared to 67 percent who are covered under a health insurance policy.

Table 6

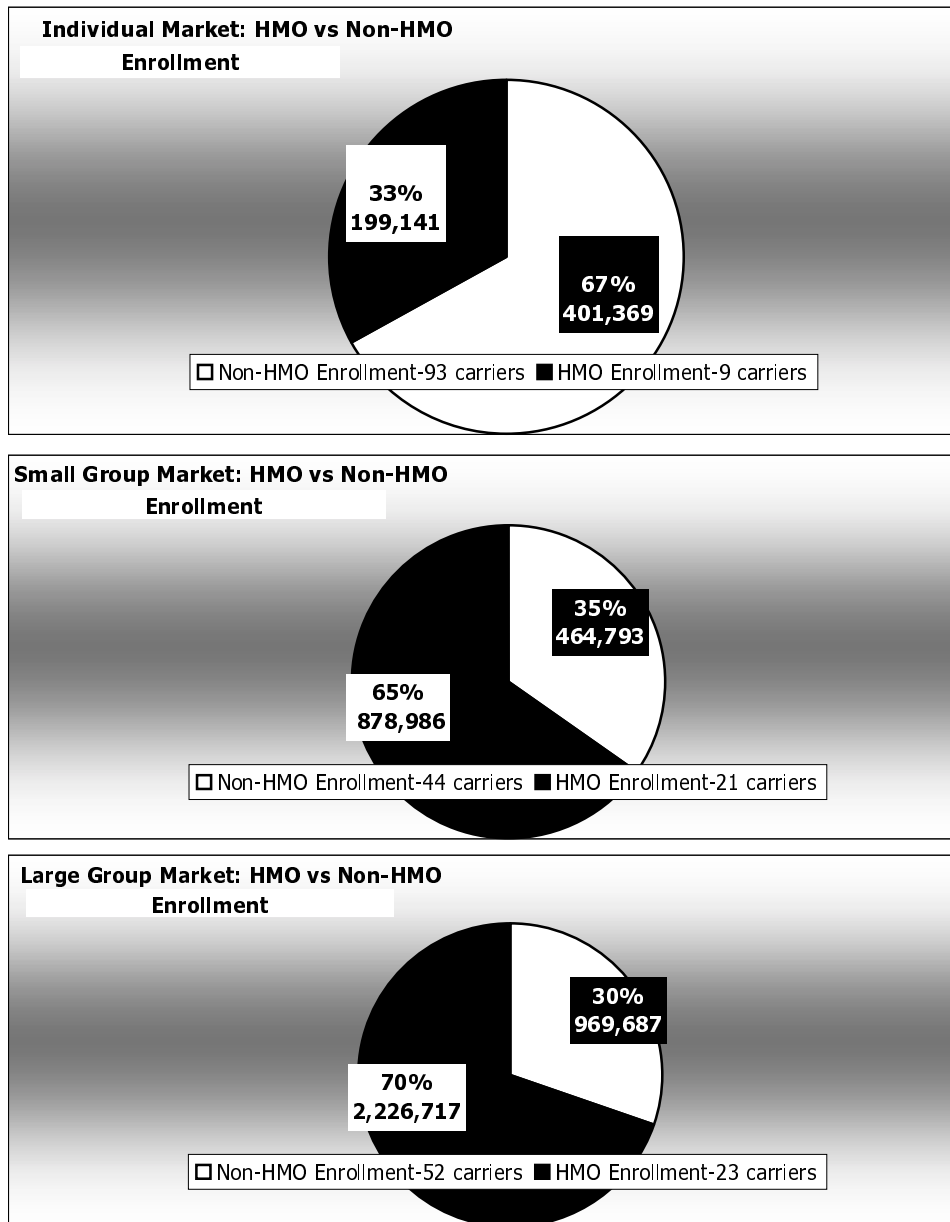


Table 8 below (“Summary of Enrollment Information”) provides additional detail about the persons insured in each market. Small group policies were issued to 153,564 small employers in Florida insuring an average of 5.19 employees per policy. Adding dependents, the average small group policy insured 8.75 persons. Almost one-third of all small group policies (49,665) were sold to one-life groups covering a single employee or self-employed individual. Since all carriers were not able to separately report their one-life group data, the actual number of one-life group policies is even higher.

In the large group market, policies issued to 30,940 employers insure an average of 53 employees per policy. Adding dependents, the average large group policy insures 103 persons.

In the individual market, 600,510 persons were covered under policies issued to 384,535 primary insureds, indicating that the typical individual policy also covers the insured’s spouse. Only 11,075 of these policies, representing 2.88 percent of the total, were sold on a guarantee-issue basis to HIPAA-eligible individuals. The other 97 percent of the individual policies required that the applicant pass the underwriting requirements of the insurer as a condition of obtaining coverage. Table 8 also separates the data for policies issued in Florida (“instate”) and policies issued outside of Florida (“out-of-state”).

As highlighted on Table 7 below, 27 percent of persons covered in the individual market, or 164,409 persons, are covered under out-of-state policies which are not subject to rate regulation and other requirements of Florida law. In contrast, for both the small group and large group markets, less than five percent of lives are covered under out-of-state group policies.

Table 7

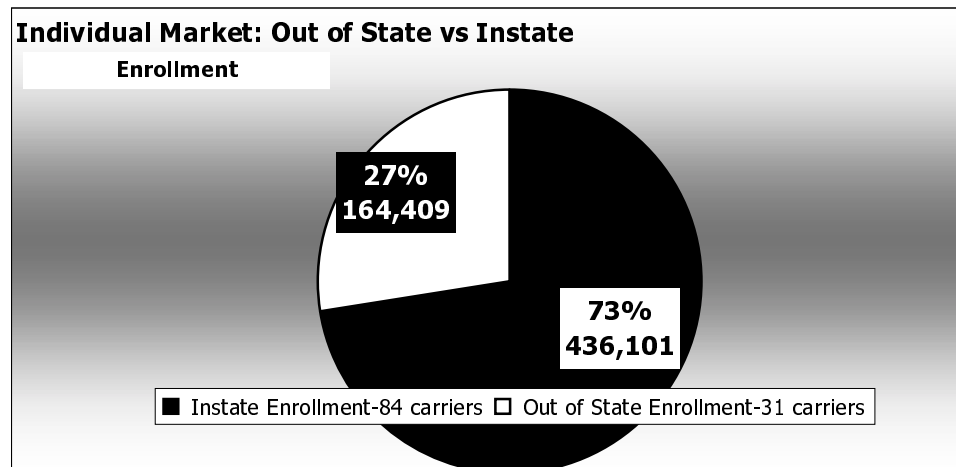


Table 8
SUMMARY OF ENROLLMENT INFORMATION
Calendar Year 2000

COVERED LIVES		INSUREDS		EMPLOYERS		INSUREDS per EMPLOYEE	LIVES per EMPLOYER	
total	% of total	total	% of total	total	% of total			
Individual Market								
Instate								
guarantee issue (HIPAA)	12,220	2.03%	10,168					2.64%
individually underwritten	423,881	70.59%	290,941					75.66%
instate total	436,101	72.62%	301,109					78.30%
Out of State								
guarantee issue (HIPAA)	1,119	0.19%	907					0.24%
individually underwritten	163,290	27.19%	82,519					21.46%
out of state total	164,409	27.38%	83,426					21.70%
Combined								
guarantee issue (HIPAA)	13,339	2.22%	11,075					2.88%
individually underwritten	587,171	97.78%	373,460	97.12%				
combined total	600,510	100.00%	384,535	100.00%				
Small Group Market (not all carriers able to differentiate between one life and 2-50 member group categories)								
Instate								
small group (one-life)	97,013	7.22%	47,739	5.99%	47,404	30.87%	1.01	2.05
small group (2-50)	1,181,229	87.90%	713,387	89.45%	95,503	62.19%	7.47	12.37
instate total	1,278,242	95.12%	761,126	95.44%	142,907	93.06%	5.33	8.94
Out of State								
small group (one-life)	4,630	0.34%	1,926	0.24%	1,929	1.26%	1.00	2.40
small group (2-50)	60,907	4.53%	34,457	4.32%	8,728	5.68%	3.95	6.98
out of state total	65,537	4.88%	36,383	4.56%	10,657	6.94%	3.41	6.15
Combined								
small group (one-life)	101,643	7.56%	49,665	6.23%	49,333	32.13%	1.01	2.06
small group (2-50)	1,242,136	92.44%	747,844	93.77%	104,231	67.87%	7.17	11.92
combined total	1,343,779	100.00%	797,509	100.00%	153,564	100.00%	5.19	8.75
Large Group Market								
Instate								
instate total	3,040,430	95.12%	1,548,120	94.30%	26,964	87.15%	57.41	112.76
Out of State								
out of state total	155,974	4.88%	93,509	5.70%	3,976	12.85%	23.52	39.23
Combined								
combined total	3,196,404	100.00%	1,641,629	100.00%	30,940	100.00%	53.06	103.31

Table 9 below lists the top 20 individual carriers, by premium volume, in Florida. The largest carrier, Blue Cross and Blue Shield of Florida, has nearly three times the premium volume of the second largest carrier, United Healthcare of Florida. The state's third largest individual carrier, United Wisconsin Life Insurance Company, writes exclusively out-of-state group policies. In all, eight of the top 20 carriers either write individual coverage in Florida exclusively through out-of-state group policies (five carriers), or have a much greater premium volume from out-of-state group policies compared to their in-state policies (three carriers).

Table 9
Individual Coverage --Top Twenty Carriers by Premium
Earned In Florida
(Including Out-of-State Group Policies)

Individual Carrier	In State Policies		Out-of-State Policies		Total Policies	
	Premium Earned	Covered Lives	Premium Earned	Covered Lives	Premium Earned	Covered Lives
1. Blue Cross and Blue Shield of Florida	\$210,059,190	178,947	\$0	0	\$210,059,190	178,947
2. United Healthcare of Florida	\$74,648,845	37,268	\$0	0	\$74,648,190	37,268
3. United Wisconsin Life Insurance Co.	\$0	0	\$61,972,645	38,646	\$61,972,645	38,646
4. Foundation Health, a Fla. Health Plan	\$53,540,071	38,841	\$0	0	\$53,540,071	38,841
5. Well Care HMO	\$40,973,208	21,695	\$0	0	\$40,973,208	21,695
6. Golden Rule Insurance Co.	\$2,761,790	673	\$28,857,686	25,664	\$31,619,476	26,337
7. United Benefit Life Ins. Co.	\$0	0	\$24,953,375	12,494	\$24,953,375	12,494
8. Preferred Medical Plan	\$22,952,250	29,537	\$0	0	\$22,952,250	29,537
9. Total Health Choice	\$21,596,843	13,667	\$0	0	\$21,596,843	13,667
10. Celtic Insurance Co.	\$0	0	\$19,946,713	15,125	\$19,946,713	15,125
11. State Farm Mutual Auto. Ins. Co.	\$18,199,280	11,416	\$0	0	\$18,199,280	11,416
12. Health Options	\$15,215,507	38,383	\$0	0	\$15,215,507	38,383
13. Mega Life and Health Ins. Co.	\$0	0	\$14,661,274	8,801	\$14,661,274	8,801
14. Mutual of Omaha Ins. Co.	\$13,541,742	14,080	\$0	0	\$13,541,742	14,080
15. Provident American Life and Health Insurance Co.	\$0	0	\$11,645,560	9,055	\$11,645,560	9,055
16. American National Life Ins. Co. of Texas	\$2,572,835	988	\$8,096,255	7,520	\$10,669,090	8,508
17. Freedom Life Insurance Company of America	\$25,994	17	\$10,457,299	13,711	\$10,483,293	13,728
18. Continental General Ins. Co.	\$9,985,298	4,197	\$0	0	\$9,985,298	4,197
19. Physicians Healthcare Plans	\$9,120,940	1,413	\$0	0	\$9,120,940	1,413
20. Beacon Health Plans	\$8,624,898	16,322	\$0	0	\$8,624,898	16,322

Conclusions and Recommendations

The conclusions outlined below were drawn from the extensive information collected in the Florida Health Insurance Study (FHIS) for the Agency for Health Care Administration and by the Department of Insurance in their “data call” of health insurers. This information may be helpful for policymakers in assessing Florida’s health insurance market.

1. **The uninsured rate in Florida is estimated to range between 2.1 million or 16.8 percent of the population (1999 FHIS report) to 2.8 million or 19 percent of the population (2000 Census Data).**³⁷
2. **According to the FHIS report, most uninsured (74.1 percent) cite affordability as the main reason for not having health insurance.**
3. **Almost 63 percent of Floridians respond in the FHIS report that they have health insurance coverage through their current employer or union while only nine percent report that they have health insurance purchased on their own and not through an employer or union.**
4. **Any legislation that would apply to “all insurers” would impact only 34 percent of the state’s population because present insurance covers 5,140,693 Floridians, e.g., 34.2 percent.**

Insurance Carriers	Covered Lives	Percent
Insured Covered Lives	5,140,693	34.2%
Total Florida Population	15,052,000	100.0%

5. **The insured market is dominated by large group coverages, which represents more than 62 percent of the market. Small group coverages represent 26 percent of the insured market while individual business represents less than 12 percent of the market.**

Line of Business	Covered Lives	Percent
Individual	600,510	11.7%
Small Group	1,343,779	26.1%
Large Group	3,196,404	62.2%
Total	5,140,693	100.0%

6. **Twenty-seven percent of the individual policies written for Florida residents are written through out of state associations which *are exempt* from**

³⁷ The FHIS estimate for the uninsured was limited to Floridians under age 65 while the U.S. Census data included all Floridians who responded to the Census survey.

Florida's rating law and thus do not provide consumers with the same protections that are afforded to policies issued in Florida.

Individual Business	Covered Lives	Percent
In-state	436,101	72.6%
Out-of-State	164,409	27.3%
Total	600,510	100.0%

7. Instate carriers report that one out of every 36 policies, 2.8 percent, are issued on a guarantee-issue basis to persons eligible under HIPAA (Health Insurance Portability and Accountability Act). The ratio reported by out-of-state associations is only one out of every 147 policies or 0.7 percent, are HIPAA.

Individual Business	HIPAA Lives	Total Lives	Percent
In-state	12,220	436,101	2.8%
Out-of-State	1,119	164,409	0.7%

8. Average group size in the small group market is reported at 5.2 insureds (employees) and 8.8 lives per group.

Small Group Business	Groups	Insureds	Covered Lives
Number	153,564	797,509	1,343,779
Number per Group		5.2	8.8

9. Carriers who were able to break out their small group enrollment by one-life group vs. other, report that one-life groups represent 34.8 percent of the total small groups but only 8.2 percent of the small group covered lives.

Small Group Business	Groups	Insureds	Covered Lives
One-Life	49,333	49,665	101,643
Total	141,801	746,744	1,238,961
One-Life per Group	34.8%	6.7%	8.2%

Appendixes

Appendix A: U. S. Census Data for 2000 — Health Insurance Coverage by State

Appendix B: Department of Insurance Special Data Call for Health Industry Premium and Enrollment Information

Appendix C: All Data Contributing Carriers Sorted by Premium Reported

Appendix D: All Data Contributing Carriers Sorted by Carrier

Appendix E: Large Group Data Contributing Carriers

Appendix F: Small Group Contributing Carriers

Appendix G: Individual Data Contributing Carriers

Appendix H: Florida Health Maintenance Organizations Enrollment and Premium

Appendix I: Carriers with Non-Mutually Exclusive Stop Loss/ASO Data