Review of Florida's Health Insurance Laws Relating to Rates and Access to Coverage

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Background

Overview of Florida's Health Insurance Reforms

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 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.

Florida has been more aggressive in its small group reforms, as compared to the laws affecting individual health insurance coverage. Since 1993, Florida law has required insurers to guaranteed-issue coverage to all small employers with one to fifty employees, and to disregard all health factors in setting a small employer's premiums. In that same year, Florida established eleven community health purchasing alliances as state-chartered, nonprofit private organizations, to broker health insurance coverage to small employers.

In contrast, Florida law does not require guaranteed-issuance of individual coverage unless the individual had coverage within the prior 63 days. Community rating is not imposed on individual policies, thereby allowing insurers to charge higher rates to persons with identified health problems. But, state law limits the extent to which insurers may segregate high-risk individuals into separate rating pools, so as to protect against future rate increases.

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. 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 statute 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.

The state law exempts out-of-state group policies from rate regulation. Out-of-state group policies are a hybrid of group and individual coverage that is marketed to individuals in Florida under a group policy issued to an association in another state. 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.

Individual Health Coverage

No Guaranteed-issue or High-Risk Pool — 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 their health status. 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. 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, such as the policyholder moving outside of the plan's service area or an insurer electing to terminate all individual coverage in the state.

Continuation of Prior Coverage — The federal Health Insurance Portability and Accountability Act (HIPAA) and conforming Florida law allows 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.[1] 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

[1] Section 627.6487, F.S.

coverage, if the prior coverage was terminated because the insurer became insolvent or the insurer discontined 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 Consolidated Omnibus Budget Reconciliation Act of 1985 (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 to persons who lose their eligibility for the group coverage. The group insurer must offer at least two conversion policy options, including the standard benefit plan that Florida law requires small group carriers to offer. 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, assuming the individual belongs to the group or association issued the master policy, which is often merely a formality.

There is no statutory limit on the premium that may be charged HIPAA-eligible persons who are not eligible for a conversion policy (which is subject to a premium cap of 200 percent of the standard risk rate). 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 an independent factor.

Small Group Coverage

Guaranteed-Issuance 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 that applies for coverage, regardless of the health condition of the employees.[2] In 1993, the act was expanded to cover employers with one to fifty 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 two to fifty employees, not to one-employee groups or sole proprietors.

The Florida act further requires that insurers set rates for small group 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, or any other factor.

An insurer or HMO that writes small group policies in Florida must elect to be a risk-assuming carrier and assume all risk, or be a reinsuring carrier and have the option of reinsuring identified high-risk individuals or groups with a state-created reinsurance pool. The reinsurance pool is funded through premiums paid by reinsuring carriers and by assessments on all health insurers other than risk-assuming carriers.

Small group carriers are required to offer a *standard* and *basic* policy to small employers. The standard policy is a major medical policy and the basic policy is a more affordable, lower benefit option. The statute mandates certain benefits that must be included in both policies and creates a Health Benefit Plan Committee to develop and modify the plans. Small group carriers are required to offer all health benefit plans on a guaranteed-issue basis, but increased benefits may be added to the standard benefit plan by rider and may be medically underwritten.

Community Health Purchasing Alliances — In 1993, the Florida Legislature established Community Health Purchasing Alliances (CHPAs) as state-chartered, nonprofit private organizations, intended to pool purchasers of health care

[2] Section 627.6699, F.S.

together in organizations that broker health plans at the lowest price and enable consumers to make informed selections of health plans.[3] CHPAs make available health insurance plans to small employers with one to fifty employees, including sole proprietors and self-employed individuals. The Agency for Health Care Administration (AHCA) is responsible for oversight, including technical and legal assistance, liaison functions, and designation of the insurers and HMOs authorized to offer coverage, referred to as "accountable health partnerships" (AHPs). CHPAs essentially act as clearing-houses for health insurance plans from carriers that elect to participate and respond to requests for proposals.

The law created eleven CHPAs, one for each of AHCA's health service planning districts. There are now eight individual CHPAs, due to the merger of certain districts. Each CHPA operates under the direction of an appointed seventeen-member board of directors. The statute was repealed that provided for appointment of board members by public officials, but the CHPAs' articles and bylaws continue to provide for statutory method of appointment.

Many insurers and HMOs have withdrawn from participating in CHPAs and the number of small employers obtaining coverage through CHPAs has also decreased, discussed in Findings, below.

Rate Regulation for Health Insurance

Rating Law — Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance.[4] 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 by the department. These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies. Legislation enacted in 1999 imposed the same rating procedures for health maintenance organizations contracts.

Standards for Disapproval — 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*, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which

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[3] Chapter. 93-129, L.O.F.; ss. 408.70-408.706, F.S.

[4] Sections 627.410 and 627.411, F.S.

encourage misrepresentation, 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.[5]"

Minimum Loss Ratios Established by Rule — Based on the above standard, current department rules establish minimum loss ratios for all types of health insurance policy forms.[6] 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.

For over a year, the department has attempted to revise their health insurance rating rules, currently subject to an administrative challenge. One issue is a proposed rule definition of *viable* as used in the statute that allows the department to disapprove a premium increase that is *not viable for the policyholder market*.

Specific "Lowball" Rating Practices Prohibited — 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.[7]

Required Pooling of Claims Experience Under All Similar Policy Forms — 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

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[5] Section 627.411(1)(e), F.S.

[6] Rule 4-149, Fla. Admin. Code

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

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.[8] The department's proposed rule amendments include a definition of "similar benefits" which would apply to these statutory requirements.

Annual Rate Certification — 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.[9] 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.

Loss Ratio Guarantee — 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.[10] 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. The insurer must obtain approval from the department for its initial rates and the established loss ratios. A subsequent rate filing to increase rates is deemed approved upon filing if it is accompanied by the loss ratio and refund guarantee. The statute specifies requirements for calculating and demonstrating whether loss ratio guarantees are met, including an independent audit and authority for the department to establish by rule the minimum information reasonably necessary to be included in the report.

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[8] Section 627.410(6)(d)-(e), F.S.

[9] Section 627.410(7), F.S.

[10] Section 627.410(8), F.S.

Out-of-State Group Policies —The state law generally exempts out-of-state group policies from rate regulation.[11] The rating requirements described above do not apply to such policies, which are marketed to individuals in Florida, but are issued to a group or association outside of Florida. 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 offered coverage 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 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 plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium could be adjusted up to 10 percent annually, up to the total 15 percent limit, of the carrier's approved rate, based on these factors, not to exceed 5 percent annually due to health status alone.

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. The Alliance would be authorized to negotiate with one or more health insurers or HMOs to offer health plans to small employer members in one or more regions. Instead of

[11] Section 627.6515, F.S.

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 assets and liabilities of the FCHA would be transferred to the FHEA and the provisions relating to the FCHA would be repealed. It appropriates $50 million from the General Revenue Fund to the Florida Health Endowment Trust Fund which is created under a companion bill (CS/SB 1802). The board would administer the Trust Fund, establish eligibility requirements, offer policies of major medical coverage, and establish premium schedules for low-risk, medium-risk, and high-risk individuals. Insurers that contribute (voluntarily) to the FHEA earn a 100 percent credit against premium tax liability. The plan would be terminated if it becomes financially not feasible.

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. The percentages of persons insured and uninsured for these states were 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

Florida's Uninsured Rate Compared to U.S. Average; Selected States

State health insurance reforms are intended to provide access to coverage with the expectation that it will have a positive impact on the percentage of persons who obtain coverage. 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. Table 1 reflects the uninsured rate in Florida compared to the U.S. average, for the years 1995, 1996, and 1997.

TABLE 1

SOURCES OF HEALTH INSURANCE AND UNINSURED RATE
NONELDERLY POPULATION (AGES 0-64)
1995-1997

1997	Total Private Insurance			Public Coverage (including Medicaid)	Uninsured Rate
	Total Private	Employer	Other Private		
U.S.	70.9%	64.2%	6.7%	14.8%	18.3%
Florida	65.6%	57.5%	8.1%	14.0%	23.7%
1996					
U.S.	70.9%	64.0%	6.8%	16.0%	17.7%
Florida	64.9%	56.4%	8.5%	17.5%	22.9%
1995					
U.S.	70.7%	63.8%	6.9%	16.6%	17.4%
Florida	65.2%	56.1%	9.1%	17.7%	21.8%

Source: Employees Benefit Research Institute

As reflected Table 1, the uninsured rate for the nonelderly has continued to

climb in Florida and nationwide and Florida's rate has remained well above the U.S. average for each of the last 3 years. In fact, the gap between Florida and the U.S. average has widened from 4.4 percentage points in 1995, to 5.4 points in 1997. Similarly, Florida has consistently had a lower percentage of persons with employer-based coverage as compared to the national average. However, Florida experienced a modest gain in the rate of persons with employer-based coverage, increasing 1.4 percentage points from 56.1 percent in 1995 to 57.5 percent in 1997, which is greater than the 0.4 percentage point gain in the national average from 63.8 percent in 1995 to 64.2 percent in 1997.

Later in this report, Florida's health insurance laws are compared to fourteen other states, selected as the most populous states or states identified as enacting significant health care reforms. Table 2 shows the uninsured rate and source of coverage in each of these states for 1997.

TABLE 2
SOURCES OF INSURANCE/UNINSURED RATE
NONELDERLY POPULATION (AGES 0-64)
BY STATE, 1997

State	Total Private			Public (Including Medicaid)	Uninsured Rate
	Total Private	Employer	Other Private		
California	63.0%	56.0%	7.0%	16.4%	23.8%
Colorado	76.7%	67.9%	8.8%	10.3%	16.5%
Connecticut	79.1%	74.2%	4.9%	10.0%	13.8%
Florida	**65.6%**	**57.5%**	**8.1%**	**14.0%**	**23.7%**
Georgia	67.9%	63.0%	4.9%	18.4%	19.5%
Illinois	77.1%	70.9%	6.1%	12.0%	13.9%
Indiana	82.2%	75.1%	7.1%	7.3%	12.8%
Kentucky	68.8%	62.0%	6.0%	20.4%	17.0%
Massachusetts	74.2%	68.3%	5.9%	16.1%	14.3%
Minnesota	79.7%	70.0%	9.6%	15.9%	10.2%
New Jersey	74.6%	69.1%	5.4%	9.4%	18.4%
New York	65.4%	60.3%	5.0%	17.2%	20.0%
Oregon	76.3%	68.0%	8.3%	14.5%	14.8%
Pennsylvania	78.6%	72.4%	6.2%	13.5%	11.7%
Texas	63.1%	58.1%	5.0%	14.0%	26.8%
U.S. (50-state) Average	**70.9%**	**64.2%**	**6.7%**	**14.8%**	**18.3%**

Source: Employee Benefits Research Institute

The Small Group Insurance Market in Florida

Table 3 reflects the number of persons insured under small group policies in Florida since 1993, when the small group insurance reforms were enacted, through March 1999, which reflects a steady increase. Table 4 cites the number

of carriers writing small group coverage in the state for each of the last 3 years which has decreased slightly. However, 90 carriers are currently offering small group coverage, which reflects a fairly healthy market providing small employers with competitive products.

TABLE 3
FLORIDA SMALL GROUP MARKET ENROLLMENT TRENDS
1993-1998

Total Insured	1993	1994	1995	1996	1997	1998	As of March 31, 1999
	162,868*	508,770*	1,304,379	1,447,964	1,636,047	1,712,227	1,734,833

*Note: Data collection methodology later revised.
Sources: Department of Insurance and Florida Small Employers Health Reinsurance Program

TABLE 4
NUMBER OF SMALL EMPLOYER CARRIERS IN FLORIDA
1997-1998

Type of Coverage	1997	1998	1999
Insurers	81	61	61
HMOs	35	29	29
Total	116	90	90

Source: Department of Insurance

Table 5 shows the average annual rate increases for small group coverage in Florida for the 3-year period, 1995-1997, weighted for market share for the leading thirteen health insurers[12] representing 79.8 percent of the small group market and the six HMOs[13] representing 83.6 percent of the small group HMO market in 1997. These rate increases have been substantial, averaging over 17 percent a year for small group insurers and nearly 10 percent a year for small group HMOs.

Table 5
Small Group Rates — Average Annual Rate Increase
Leading Florida Carriers (1995-1997)

Year	**Small Group Insurance**	**Small Group HMO**
1995	21.16%	9.03%
1996	17.18%	7.12%
1997	14.06%	11.50%
3-Year Cumulative Total	61.93%	30.23%
Average Annual Change	17.43%	9.20%

Source: Florida Department of Insurance

[12] Blue Cross & Blue Shield of Florida (17.18% market share), Principal Mutual Life Insur. Co. (13.53%), John Alden Life Insur. Co. (12.46%), Humana Health Insur. Co. of Fla. (8.48%), United HealthCare Insur. Co. (7.41%), PFL Life Insur. Co. (2.01%), and Time Insur. Co. (1.84%).

[13] Health Options (18.39% market share), Humana Medical Plan (18.04 %), United HealthCare Plans of Fla. (15.13%), Principal Health Care of Fla. (13.9%), Prudential Health Care of Fla. (13.9%), and Neighborhood Health Partnership (4.2%).

Table 6 shows the most current rate filings that have been approved by the department for small group insurers and small group HMOs, as of August 1,1999, and the average premium per covered employee for a sample 10-life group developed by the department. Small group premiums are continuing to increase at significant levels. Unlike previous years, HMOs are experiencing rate increases comparable with health insurers.

TABLE 6
MOST RECENT FLORIDA SMALL GROUP RATE FILINGS
(APPROVED AS OF 8/1/99)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase (Avg.)
Small Group Major Medical —Indemnity:		
Principal Life Ins. Co.	22.0%	$5,291 ($441)
Anthem Health and Life Ins. Co.	11.2%	$5,463 ($455)
Blue Cross/Blue Shield	14.6%	$4,953 ($413)
Aetna Life Ins. Co.	13.1%	$6,269 ($522)
Humana Health Ins. Co. of Fla.	12.0%	$5,189 ($432)
PM Group Life Ins. Co.	0.7%	$4,048 ($337)
Prudential Life Ins. Co.	14.0%	$3,587 ($299)
Anthem Health and Life Ins. Co.	11.8%	$5,173 ($431)
New England Life Ins. Co.	0.0%	$5,117 ($426)
Trustmark Ins. Co.	10.0%	$6,568 ($547)
Principal Life Ins. Co.	17.0%	$6,221 ($518)
United Wisconsin Ins. Co.	23.0%	$3,241 ($270)
Small Group HMO (Out of CHPA)		
HIP Health Plan of Florida	18.1%	$4,558 ($380)
Aetna US HealthCare	20.1%	$4,139 ($345)
Health Options	24.1%	$4,773 ($398)
Healthplan Southeast	8.3%	$4,155 ($346)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase (Avg.)
Small Group HMO (Out of CHPA) (continued)		
Well Care HMO	2.9%	$4,475 ($373)
Florida Health Care Plan	19.5%	$4,121 ($343)
Foundation HealthCare	14.7%	$3,522 ($294)
American Medical HealthCare	25.4%	$3,634 ($303)
Physicians HealthCare Plans	29.1%	$5,239 ($437)
Health First Health Plan	10.9%	$3,689 ($307)
Small Group Point of Service:		
American Med HealthCare & United Wisconsin Insur.	25.4%	$3,568 ($297)
HIP Ins. Co. of Fl & HIP Plan	New	$3,950 ($329)
United HealthCare & United Ins. Co.	20.7%	$3,697 ($309)

Source: Florida Department of Insurance

Community Health Purchasing Alliances (CHPAs)

As of July 1999, 67,746 employees and their dependents were insured through CHPAs, representing 18,169 small employer groups. As recently as February 1999, 86,766 persons were insured through CHPAs, representing 22,033 small employer groups, 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. The Agency for Health Care Administration reports that 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, as listed below.

Carriers Withdrawing From CHPAs
Aetna US Healthcare
Blue Cross & Blue Shield of Florida
CIGNA HealthCare of Florida
Connecticut General Life Insurance Company

Florida 1st Health Plans
Foundation Health, A Florida Health Plan
Health 1st Health Plans
Health Options
HIP Health Plan of Florida
Humana Health Insurance Company of Florida
Physicians Healthcare Plans
Prudential Health Carte Plans
Prudential Insurance Company of America
United HealthCare of Florida

Carriers Remaining in CHPAs
Av-Med Health Plan
Beacon Health Plans
Capital Group Health Services of Florida
Florida Health Care Plan
Healthplan Southeast
Humana Medical Plan
Neighborhood Health Partnership
The Public Health Trust of Dade County Florida
SunStar Health Plan
Well Care HMO

CHPAs are limited in their ability to have a significant impact in reducing the number of uninsured Floridians. The following limitations were cited in a 1998 report by the Office of Program Policy Analysis and Government Accountability[14]:

- CHPAs inability to negotiate or select health plans that offer the most competitive products and prices; and

- CHPAs dependence on agents designated by health plans to sell CHPA products, and to further improve access to affordable health care coverage.

Florida Large Group Insurance Market

Coverage for large employers in Florida appears to be widely available. There is general agreement that large employer size and market competition help protect

[14] *The Follow-Up Report on the Status of Community Health Purchasing Alliances in Florida*, (Report No. 98-14, October 1998).

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. For mid-size employers, with 100 to 500 employees, carriers are more likely to have a blend of experience rating and manual rating. Manual rates are filed by the carrier for general applicability to group policies and are subject to more stringent departmental review.

Table 7 below shows the average annual rate change for large group coverage (greater than 50 employees or certificate holders) for the 3-period of 1995-1997. These are the average rate changes for the eight insurers[15] that account for 79 percent of the large group health insurance premium volume in Florida and the five HMOs[16] that account for 82% of the large group HMO premium volume in 1997:

TABLE 7
LARGE GROUP RATES — AVERAGE ANNUAL RATE INCREASE
LEADING FLORIDA CARRIERS (1995-1997)

Year	Large Group Insurance	Large Group HMO
1995	13.62	5.67
1996	7.69	6.57
1997	6.24	5.51

Source: Florida Department of Insurance

[15] Blue Cross & Blue Shield (46% market share), Humana Health Ins. Co. (12.4%), Principal Mutual Life Ins. Co. (5.4%), Connecticut General Life Ins. Co. (5.2%), United HealthCare Ins. Co. (4.4%), Aetna Life Ins. Co. (3.5%), and The Prudential Ins. Co. (2.4%).

[16] Humana Medical Plan (42.6% market share), Prudential Health Care Plan (16.8%), Health Options (14.5%), and AV-MED (8%).

Table 8 shows the most recent large group rate filings that have been approved by the department, as of August 1, 1999, and the average premium per covered employee:

TABLE 8
MOST RECENT FLORIDA LARGE GROUP RATE FILINGS

Company	Percentage Increase	Annual (& Monthly) Premium After Increase
Large Group Major Medical — Indemnity:		
Principal Life Ins. Co.	10.5%	$3,041 ($253)
Aetna Life Ins. Co.	9.2%	$4,256 ($355)
Blue Cross/Blue Shield	7.0%	$3,483 ($290)
Foundation Health National Life Ins. Co.	9.0%	$4,093 ($341)
Cuna Life Ins. Co.	12.0%	$3,550 ($296)
Large Group Major Medical - Indemnity (continued)		
First Allmerica Ins. Co.	14.3%	$3,931 ($328)
Principal Life Ins. Co.	5.6%	$2,734 ($228)
Guardian Life Ins. Co.	11.4%	$3,716 ($310)
Allianz Life Ins. Co. of North America	8.0%	$2,950 ($246)
United Wisconsin Life Ins. Co.	8.0%	$2,414 ($201)
Anthem Health and Life Ins. Co.	14.0%	$4,275 ($356)
Large Group HMO:		
Capital Group Health Services of Fla.	18.0%	$3,364 ($280)
Av-Med	10.4%	$4,212 ($351)
United HealthCare of Fla.	5.5%	$3,502 ($292)
Health Options	7.0%	$3,539 ($295)
Aetna US HealthCare	17.3%	$4,525 ($377)
Human Medical Plan	2.7%	$3,458 ($288)
Beacon Health Plan	14.4%	$2,838 ($237)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase
Large Group HMO: continued		
HIP Health Plan of Fla.	15.4%	$3,774 ($315)
Health First Health Plans	10.1%	$2,751 ($229)
Principal Health Care of Florida	5.5%	$3,324 ($277)
Foundation Health Plan	10.5%	$2,580 ($215)
Prudential HealthCare of Fla.	12.7%	$3,685 ($307)
CIGNA HealthCare of Fla.	12.7%	$3,685 ($307)
Large Group Point of Service:		
United HealthCare of Fla.	5.5%	$4,034 ($336)
Health Options & Blue Cross Blue Shield	6.6%	$3,385 ($282)
Community H C Systems & Fortis Benefits Ins. Co.	21.1%	$3,218 ($268)
United Wisconsin & American Medical HC	15.7%	$3,628 ($302)
Florida HealthCare Plans & Alliance Life Ins. Co.	New	$3,377 ($281)

Source: Florida Department of Insurance

Florida Individual Insurance Market

The Department of Insurance identifies 38 insurers and HMOs that are writing individual coverage in the state, but this figure includes insurers that may only be renewing coverage, insurers writing limited benefit policies (hospital and surgical only, etc.), HMOs issuing individual coverage in limited areas of the state, and insurers issuing coverage through out-of-state associations. In fact, 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 eleven health maintenance organizations that issue individual HMO contracts, but coverage is limited to certain geographical service areas. There are fifteen insurers identified as issuing coverage only through out-of-state associations and

nine insurers identified as either issuing limited benefit policies or not actively writing new policies. In summary, Florida appears to have a fragile and fragmented individual market.

Benefits differ greatly among the various types of individual health insurance coverage, making premium comparisons difficult. However, a review of the most recent major medical rate, individual coverage filings, as approved by the department, illustrates the percentage increases that have been obtained and the annual premiums under these policies, as shown on Table 9:

TABLE 9
MOST RECENT FLORIDA INDIVIDUAL RATE FILINGS
(APPROVED AS OF 8/1/99)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase
Individual Major Medical — Indemnity:		
American Pioneer Ins. Co.	13.4%	$4,205 ($350)
Mutual of Omaha Ins. Co.	18.9%	$3,657 ($305)
Guarantee Trust Life Ins. Co.	14.0%	$2,608 ($217)
Trustmark	19.0%	$3,732 ($311)
Lutheran Brotherhood	14.0%	$2,604 ($217)
Continental General Ins. Co.	14.0%	$1,944 ($162)
Pyramid Life	9.5%	$4,200 ($350)
Union Bankers Ins. Co.	5.0%	$3,387 ($282)
Blue Cross Blue Shield	6.2%	$2,400 ($200)
Central States Health & Life	15.0%	$2,959 ($247)
Kanawha Insurance Co.	15.0%	$1,625 ($135)
Individual HMO:		
Beacon Health Plan	25.4%	$2,100 ($175)
Preferred Medical Plan	10.4%	$1,531 ($128
Foundation Health	12.0%	$1,452 ($121)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase
Individual HMO: continued		
Health Options	16.9%	$1,480 ($123)
United Health Care	16.2%	$1,903 ($159)
PCA Family Health Plan	16.9%	$2,291 ($191)
Physicians Health Care Plans	20.1%	$1,514 ($126)

Source: Florida Department of Insurance

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. For example, for Blue Cross & Blue Shield, which writes the largest volume of individual coverage in the state, the department has approved two nonstandard rating categories with surcharges of 45 percent and 75 percent above the standard rate. 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. Blue Cross & Blue Shield, for example, has three rating pools for its individual coverage -- indemnity policies, preferred provider policies, and conversion policies. 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.

An interim project last year by this committee addressed the subject of surcharging individuals eligible for guaranteed-issuance of coverage under the federal HIPAA and state law.[17] The report found that carriers issuing individual policies in the state were generally not surcharging policies sold to HIPAA-eligible individuals, primarily due to department actions. However, some of the carriers identified as issuing individual certificates of coverage in Florida under out-of-state group policies were imposing 100 to 200 percent surcharges on

[17] Interim Report 98-05, *Rating Practices of Insurers Issuing Health Insurance Policies and Certificates to Individuals who are Eligible for Guaranteed-Issuance of Coverage*

HIPAA-eligible individuals.

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.

Comparison of Florida with Other State Health Insurance Laws

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, Florida, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Oregon, Pennsylvania, and Texas. The comparison focused on: (1) the types of health insurance rate filing requirements that applied in each state; (2) the definition and size of "small employer" for purposes of small group guaranteed-issue requirements, (3) the extent to which each state's small group law allowed the carrier to consider health factors in setting rates; (4) whether the state had either guaranteed-issue or a high-risk pool for providing individual coverage; (5) the method each state used for providing coverage to HIPAA-eligible individuals. Below, Tables 10, 11, and 12 summarize the key features of each state's law.

TABLE 10
HEALTH INSURANCE
RATE FILING REQUIREMENTS

State	Type of Filing	Filing Required	Annual Rate Certification (Unable to obtain information for all states)
California	Individual Small Group	File and Use File and Use	
Colorado	Individual, Group HMOs	File and Use File and Use (30 days)	Small Group
Connecticut	Individual Group HMOs	Prior Approval (30 day deemer) File and Use (30 days) Prior Approval	Individual, Small Group
Florida	Individual, Group, HMOs	Prior Approval (30 day deemer)	All
Georgia	Individual, HMOs	Prior Approval	Small Group
Illinois	All health	File and Use	
Indiana	Individual, HMO Group	Prior Approval (30 day deemer) File and Use (30 days)	Small Group
Kentucky	All health	Prior Approval (30 day deemer)	
Massachusetts	Individual (non-group) HMOs	Prior Approval No rate filing; but quarterly financial filing may trigger department rate action	Small Group
Minnesota	Individual, Group, HMOs	Prior Approval (60 day deemer)	Small Group
New Jersey	Individual	Prior Approval	

State	Type of Filing	Filing Required	Annual Rate Certification (Unable to obtain information for all states)
New York	Individual Small Group HMOs	File and Use Prior Approval (30 day deemer or deemed approved if certain loss ratios met) Prior Approval	
Oregon	Individual, small employer (2-25 employees), portability	Prior Approval	Small Group
Pennsylvania	Individual HMO and BCBS	File and Use (45 days) for new submissions Prior Approval (45 day deemer)	
Texas	Individual Small Group HMOs	File and Use Limited Filing required Formula for calculating schedules of charge must be filed.	Small Group

Sources: NAIC's Compendium of State Laws on Insurance Topics, March 1998 and interviews with state regulators.

TABLE 11
COMPARISON OF INDIVIDUAL HEALTH INSURANCE PROVISIONS

State	Guaranteed-Issue for Individual Coverage	High Risk Pool for Individual Coverage	HIPAA Eligibility Mechanism
California	no	yes	federal fallback* with federal enforcement
Colorado	no	yes	federal fallback; high risk pool, conversion
Connecticut	no	yes	high risk pool
Florida	no	no - closed for new enrollment, effective 7/1/91	conversion policies and guaranteed-issue
Georgia	no	never implemented	conversion policies and guaranteed-issue by assigned carrier
Illinois	no	yes	high risk pool
Indiana	no	yes	high risk pool and conversion policies
Kentucky	yes	no	guaranteed-issue
Massachusetts	yes (if carrier participates in small group and insures 5,000 or more lives, the carrier must participate in the individual market)	no	federal fallback with federal enforcement and other mechanism that provides risk spreading
Minnesota	no	yes	high risk pool, conversion, and HMO open enrollment
New Jersey	yes	no	guaranteed-issue and risk adjustment mechanism
New York	yes	no	guaranteed-issue

State	**Guaranteed-Issue for Individual Coverage**	**High Risk Pool for Individual Coverage**	**HIPAA Eligibility Mechanism**
Oregon	no	yes	high risk pool
Pennsylvania	no	no	other mechanism; BlueCross, insurer of last resort
Texas	no	yes	high risk pool

Sources: BlueCross BlueShield Association, State Legislative Health Care and Insurance Issues, 1998
Communicating for Agriculture, Comprehensive Health Insurance for High-Risk Individuals, 1998
NAIC's Compendium of State Laws on Insurance Topics, Health Insurance Pooling Provisions, 1999
Interviews with state regulators

*Federal Fallback - Allows an eligible individual 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, that is, regardless of the health condition of the individual. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume.

TABLE 12
COMPARISON OF SMALL GROUP SIZES AND RATING FACTORS

State	Size of Small Group (Guaranteed-Issue)	Health Factors Allowed?	Maximum Adjustment for Health Factors
California	2-50	yes	10%
Colorado	1-50	no*	*except that health factors may be used for groups of 1
Connecticut	1-50	no	
Florida	1-50	no	
Georgia	2-50	yes	25%
Illinois	2-50	yes	n/a rates are not regulated
Indiana	2-50	yes	15%
Kentucky	2-50	yes	10%
Massachusetts	1-50	no	
Minnesota	2-50	yes	25%
New Jersey	2-50	no	
New York	1-50	no	
Oregon	2-50	no*	*no rate regulation for groups of 26-50
Pennsylvania	2-50	no*	*except for groups with more than 25 employees
Texas	2-50	yes	15%

Sources: BlueCross BlueShield Association, *State Legislative Health Care and Insurance Issues, 1998,* and interviews with state regulators.

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 (California, Colorado, Connecticut, Illinois, Indiana, New York, Pennsylvania, and Texas). 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 (Connecticut, Florida, Georgia, Indiana,

Kentucky, Massachusetts, Minnesota, New Jersey, New York, Oregon, Pennsylvania). 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 appears to vary greatly among these states.

Georgia, Massachusetts, New Jersey, and Pennsylvania do not require a rate filing to be submitted for small group indemnity plans. However, 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. However, rates for small employers with 26 -50 employees are not regulated.

Rate Standards— Based on a review of rate regulations of other states and interviews with state regulators, it appears that 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, it appears that 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. If a carrier holds less than 3 percent of the individual market share, the loss ratio is set at 68 percent. If the 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. However, if a certain percentage of the business is 10 or fewer employees, the applicable ratio is 71 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.

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 1-50 (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 (California, Colorado, Georgia, Illinois, Indiana, Kentucky, Minnesota, Oregon, Pennsylvania, and Texas). 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 (Kentucky, Massachusetts, New Jersey, and New York). 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.

Conversion Policies — The premium for conversion policies issued in California is determined in accordance with the insurer's rates applicable to the age and class of risk of each person to be covered and the type of coverage provided. There are limitations on the rates for conversion policies in California.

In Connecticut, regulators have adopted an administrative position that carriers may issue conversion policies at a rate that is a maximum of 120 percent of the group rate. In California and Illinois, the rates are market driven.

In Minnesota, conversion policy rates are capped at 90 percent of the risk pool rates. Texas allows carriers to initially set conversion rates at 200 percent of the group rate. After one year, all conversions are pooled to establish the rate and no rate approval is required.

Purchasing Pools or Purchasing Alliances — According to the National Association of Insurance Commissioners and information obtained from state regulators, 10 of the 15 states reviewed have purchasing alliances authorized by law. California, Colorado, Florida, Georgia, Illinois, Kentucky, Massachusetts, Minnesota, and New York have established such alliances. However, Texas has delayed the implementation of their purchasing alliance.

Studies of State Health Care Reforms

1998 Wake Forest Study — In 1998, the Wake Forest University School of Medicine issued a report entitled, *Health Insurance Market Reform Study*, which

evaluated small group and individual reforms implemented in seven states, including three of the states reviewed in this report, Colorado, Florida, and New York. The report focused on several reforms, including: guaranteed-issue, rating bands, and community rating.

The study made the following findings about Florida's small group market reforms:

Positive Features:

1. The law has not caused major market disruptions and has not generated a large number of complaints or administrative problems;
2. The market remains highly competitive in price, product diversity, and number of carriers;
3. Prices have held steady, except for indemnity plans; and
4. CHPAs are functional and self-sustaining. Prices have been kept in line with the market, and CHPAs offer a good source of coverage for the smallest firms.

Negative Features:

1. Insurers have developed techniques to discourage enrollment of micro-groups in their most popular plans;
2. Standardized benefit plans are not selling well outside of the CHPAs;
3. Tough prior-approval rate review, coupled with the modified community rating rules, makes Florida an unattractive market for a number of indemnity insurers;
4. Carriers still compete to some extent on the basis of indirect risk selection;
5. The CHPA system has not been as successful as expected, and insurers and agents participate with a distinct lack of enthusiasm; and
6. Reinsurance is experiencing rapidly diminishing participation and use, and it has not reduced risk pool differentials.

The study noted that many carriers and HMOs claimed that insuring one-life groups had resulted in higher claims costs. One HMO indicated that the claims experience was 22 percent worse for the one-life group than for the small group block overall. Another insurer stated that the loss ratio for groups of 1-2 was 30 points higher than the groups of 10-50. Carriers also expressed concerns regarding the higher marketing and administrative costs associated with the one-life groups.

The report also noted that some insurers have implemented certain practices to discourage the enrollment of micro groups. Some of these practices include

using allowable rating factors as proxies for group size to make the small group product less affordable and attractive, requiring more documentation from employers, and delaying responsiveness to quotes and processing of applications.

The impact of the implementation of modified community rating and other rating factors were briefly discussed in the report. According to the report, few of the individuals interviewed thought that modified community rating caused groups to drop coverage due to some increases in the rates. Instead, some groups opted for lower benefits or for a managed care plan. However, the report noted that rate increases could have caused employees within a group to decline employer coverage. The use of the geographic rating factor was also discussed in the report. Current Florida law allows separate rates for each county, rather than by metropolitan statistical areas. According to the report, this allows carriers to set rates that are relatively more or less attractive for different economic or industry characteristics of the population. Also, the family size composition factor does not distinguish between various family sizes; therefore one agent was quoted as saying that it is now more costly for single parents since the size of the family is not relevant for rating.

The study made the following findings regarding the health insurance reforms in Colorado:

Positive Features:

1. The law has not caused major market disruptions and has been effectively administered;
2. The market remains highly competitive in price, product diversity, and number of carriers;
3. Enrollment has held steady or increased and standardized benefit plans have sold well;
4. Initially, prices held steady or dropped, except for indemnity plans; and
5. The CHIP (Cooperative for Health Insurance Purchase) has grown significantly.

Negative Features:

1. Prices are increasing, and initial enrollment gains are tailing off;
2. Some insurers have left the market and competition is thinning out in rural areas;
3. The CHIP and similar arrangements have only a very small percent of the market;
4. There are indications of employer fraud among micro-size firms; and

5. Participation and use of the reinsurance pool has been lower than expected.

The University of Wake Forest also evaluated the reforms in New York. In recent years, New York has implemented guaranteed-issue for individuals and also implemented pure community rating for individuals and small group. The study of reforms in New York made the following findings:

1. Enrollment - According to the study, the overall percent of the population with insurance has worsened following reform. Total enrollment in the individual and small group market has remained constant; however, enrollment in the individual market has diminished (since the reforms) to a point that, in 1998, is 38-50 percent lower than when reforms began.

2. Prices - In the individual market, prices have increased substantially. The small group market premium rates have remained relatively stable for HMO coverage and somewhat higher for PPO indemnity plans. It was noted that traditional indemnity plans have been effectively priced out of the small group market, due to adverse selection and to the absence of cost controls.

3. Small Group Market Competition- The report noted that insurers view the prior approval rate review process as adequately responsive and flexible to allow them to remain profitable or to avoid excessive losses.

4. Risk Adjustment and Administration - The report concluded that the mechanism appears to be working and it is thought that many carriers would have left the market, if it were not in place. (New York implemented a mandatory risk adjustment system that attempts to calculate how much greater or lesser each carrier's risk pool is than the market average and requires carriers' with lower risks to make payments to those with higher risks.)

5. Affordability versus Availability - Affordability appears to continue to be a major barrier to coverage.

Other Studies

In the article, *An Alternative Approach to Measuring the Effects of Insurance Market Reforms*[18], the authors attempt to evaluate the impact of health insurance reforms on the uninsured rate. The authors concluded that small group reforms

[18] Zuckerman, S. and Rajan, S. 1999. An Alternative Approach to Measuring the Effects of Insurance Market Reforms. *Inquiry* 36:44-56.

have had little impact on insurance coverage. However, the article states that small group reforms may have prevented the further erosion of private coverage and the reforms have not produced adverse effects on the number of uninsured. Individual market reforms appear to have increased uninsured rates and reduced private coverage.

The report states that reforms that reduce the carrier's ability to divide risks within a market or limiting premiums may result in increased premiums if higher-cost individuals, previously unable to purchase insurance, enter into the market. Lower-cost individuals may terminate coverage due to the increased costs of insurance that is necessary to subsidize the higher-cost individuals.

In evaluating the impact of individual market reforms, the authors note that changing rules of issue would allow individuals to purchase coverage when they anticipate needing it, and as a result, premiums would increase and coverage would be less affordable for many individuals.

Recently, in an article entitled, *Who Gains and Who Loses with Community Rating for Small Business*[19], the authors evaluated community rated and experience rated policies over a 4-year period and concluded that more high-risk firms and families purchase coverage under community rating, and low-risk firms and families are the purchasers under experience rating. It was noted that community rating increases the premium for healthy individuals and may result in some healthy individuals terminating coverage.

The benefits of community rating, as well as experience rating are also discussed. Community rating reforms attempt to increase access for high-risk individuals, to reduce rate variations, and to promote rate stability. Experience rating provides an incentive for firms to control their medical costs, since rates are tied to the claims experience of the business. However, this may result in extreme fluctuations in premiums through time, based upon the claims experience of the individuals in the group.

The authors note that the number of insureds decreased in New York, once pure community rating was implemented in the individual and group market. However, states (New Jersey, Maine, and Massachusetts) that implemented more incremental approaches (using rate bands) and phasing in reforms have had more positive results.

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[19]Buchanan, J.L., and Marquis, M. S. 1999. Who Gains and Who Loses with Community Rating for Small Business. *Inquiry* 36:30-43.

The authors estimate that the increase in coverage of high-risk families under community rating may result in a decrease of 5 percentage points in the number of working families participating in employer-sponsored plans. However, the authors state that the lower data collection costs associated with administering community rating may reduce the overall premium rates and encourage individuals to purchase coverage.

Conclusions and Recommendations

Small Group Coverage - Of the fifteen states studied, Florida is one of four that require small group carriers to guaranteed-issue coverage to one-life groups. Higher claims costs for one-life groups must be spread across all small employer policyholders and increases the costs of coverage to other small employers. One option is to provide an annual or semiannual enrollment period of 30 or 60 days for one-life groups. This would maintain access to coverage but would limit the affects of adverse enrollment which occurs when someone waits until a health problem occurs before obtaining coverage.

Florida law prohibits small group carriers from basing rates on health factors, which is allowed to some degree by nine of the fifteen states reviewed. 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.

Community health purchasing alliances (CHPAs) are declining in enrollment and carrier participation. 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. 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 - Florida is a strong rate regulation state compared to the other states studied, which is a function not only of the law itself, but of regulatory actions of

the Department of Insurance. Florida is generally perceived by insurers as an unfriendly environment for individual coverage, as evidenced by a fragmented individual market that currently relies on one major indemnity carrier, geographically limited HMOs, and largely unregulated out-of-state group carriers. 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 - Rates for large groups in Florida have been more stable than rates for small group and individual coverage. Competition and experience rating for the largest groups tend to diminish the need for state regulation to protect consumers. 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. Access to coverage is guaranteed only for individuals who had prior coverage for at least 18 months. 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. The main alternative is public financing of the subsidy needed to finance deficits, as a general cost on all taxpayers.

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 Florida Legislature has already taken the step of classifying out-of-state group policies as individual coverage for purposes of the guaranteed-issue requirements that apply to individual carriers for providing coverage to HIPAA-eligible individuals. The Legislature should consider applying the same rating laws that apply to individual coverage to out-of-state policies covering individuals in Florida.