The Florida Senate

Interim Project Summary 98-05 *October 1998*

Committee on Banking and Insurance Senator Mario Diaz-Balart, Chairman

RATING PRACTICES OF INSURERS ISSUING HEALTH INSURANCE POLICIES AND CERTIFICATES TO INDIVIDUALS WHO ARE ELIGIBLE FOR GUARANTEED-ISSUANCE OF COVERAGE

SUMMARY

The federal Health Insurance Portability and Accountability Act (HIPAA) and conforming Florida law provide that persons who no longer have group health coverage after being covered for at least 18 months must be offered individual coverage on a guaranteed-issue basis. Florida has adopted two methods of providing such coverage -- requiring group insurers to offer individual conversion policies to former group members and requiring individual carriers to offer individual policies to persons who are not eligible for a conversion policy.

HIPAA does not limit the premiums that may be charged by insurers issuing individual coverage. Under Florida law, however, premiums for conversion policies are limited to 200 percent of the standard risk rate, a statewide average rate computed by the Department of Insurance. No specific limit is placed on premiums charged for individual policies, but Florida law requires individual carriers to offer their two most popular policy forms to HIPAA-eligible individuals. The department has informed individual carriers that the law requires insurers to charge the same premium to HIPAA-eligible individuals as the rate of the most predominately sold premium class in the state (the standard rate) for their two most popular policy forms. However, Florida's rating laws do not apply to insurers issuing individual coverage in Florida under out-of-state group policies.

Reports by the U.S. General Accounting Office (GAO) found carriers charging increased premiums for guaranteed-issue policies and concluded that some consumers were finding it difficult, as a result of high premiums, to obtain the guaranteed-access coverage that HIPAA requires. This situation was likely to continue, according to the GAO, unless the federal government provided for more explicit risk-spreading requirements or states adopted explicit risk-spreading requirements of guaranteed access to coverage for HIPAA eligibles.

Based on rates filed with the department, the insurers and health maintenance organizations identified by the department as issuing individual policies in the state are generally not surcharging or "rating up" 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 are imposing 100 to 200 percent surcharges on HIPAA eligible individuals.

Individual carriers are given the option of participating in a reinsurance pool to mitigate claims expense for HIPAA-eligible individuals identified as high-risk. Reinsuring carriers must pay a reinsurance premium and retain liability for a specified percentage of claims expense for each reinsured risk, which makes the reinsurance pool a viable option only for extremely high-cost cases. Individual carriers are also subject to a potential assessment of 5 percent of premiums to fund deficits in the reinsurance pool. A potential second-tier assessment of 0.5 percent of premiums applies to all health insurance carriers, except "risk-assuming" individual carriers that do not participate in the pool.

It is recommended that the Legislature consider the following:

- Prohibit carriers issuing individual coverage from surcharging individuals based on HIPAA-eligibility status alone.
- Limit premium surcharges to 50 percent above standard rates for premiums charged by individual carriers to HIPAA-eligible individuals.

- Apply any limitation on premiums for HIPAA-eligible individuals to carriers issuing out-of-state polices covering Florida residents.

- Restructure the individual reinsurance pool to lower costs to reinsuring carriers and to spread costs more evenly over the statewide health insurance market.

BACKGROUND

Federal HIPAA and Conforming Florida Law

In 1996 Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) which requires insurers issuing individual health insurance policies to guaranty the issuance of coverage to persons who previously were covered for at least 18 months and meet other eligibility criteria. The Act allowed 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). (Ch. 97-179, Laws of Florida)

In order to be eligible for guaranteed-issuance of individual coverage, 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, 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. (Ch. 98-159, L.O.F.)

The Florida law provides two mechanisms for guaranteeing access to individual 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. One method requires the insurance company or HMO that issued the group health plan to offer an individual *conversion policy* to persons who lose their eligibility for group coverage. Florida law requires that the insurer or HMO offer at least two conversion policy options, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. The maximum premium that may be charged for any conversion policy is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Department of Insurance. (ss. 627.6675 and 641.3921, F.S.)

Florida's second method of guaranteeing access to individual coverage is by 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, 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. This is referred to as the *federal fallback method*, since it is the method that applies under HIPAA if a state fails to enact an alternative mechanism. Under Florida law, this method applies to persons who meet the eligibility criteria but who are *not* entitled to a conversion policy under sections 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 to Florida after terminating coverage from previous employment in another state. It also applies to persons whose previous coverage was under an *individual* plan that was terminated for specified reasons. However, a self-insured employer may offer conversion coverage which will disqualify a person from obtaining coverage from an individual carrier on a guaranteed-issue basis, but only if the conversion policy or contract is issued by an authorized insurer or HMO and meets the requirements specified in the respective conversion statutes. (s. 627.6487, F.S.)

Insurers issuing group policies outside the state that cover Florida residents under certificates of coverage are subject to the same guaranty-issue requirements that apply to insurers issuing individual policies in Florida. Therefore, any eligible individual (who is not eligible for a conversion policy) is entitled to obtain coverage under an out-of-state group policy on a guaranteed-issue basis, provided that the individual belongs to or joins the group or association issued the master policy, although such group membership may merely be a formality. However, Florida law does not provide for rate approval or

regulation of premiums charged for coverage under an out-of-state group policy. In contrast, insurers issuing individual policies in Florida must file their rates for approval with the Department of Insurance pursuant to ss. 627.410 and 627.411, F.S.

Concern about Increased Rates for HIPAA-Eligibles

The federal HIPAA act does not limit the premiums that may be charged by insurers issuing individual coverage. Soon after passage of HIPAA, the U.S. General Accounting Office (GAO) reported on early implementation concerns, which included a finding of increased premiums for guaranteed-issue policies with premiums ranging from 29 to 125 percent higher than standard policies issued to healthy individuals that pass medical underwriting standards. A subsequent GAO report found carriers charging premiums that were 140 to 600 percent higher than the standard rate. (More specific information on each of the two GAO reports is provided in *Findings*, below.) Various other reports and publications criticized the act as providing inadequate protection in this regard. This report reviews these studies and identifies the rates charged by insurers and HMOs issuing individual policies and contracts in Florida. In particular, the report attempts to identify the extent to which insurers surcharge or "rate up" premiums for individuals based on HIPAA-eligibility or medical underwriting.

METHODOLOGY

This study reviews previous reports by the U.S. General Accounting Office, memoranda issued by the federal Health Care Financing Administration, and bulletins issued by the Florida Department of Insurance related to rates charged by carriers to HIPAA-eligible individuals. The Department of Insurance identified those carriers issuing individual policies in Florida, health maintenance organizations issuing individual contracts in Florida, and insurers issuing individual certificates in Florida under out-of-state group policies. The department provided information on the rates filed by insurers and HMOs for policies and contracts issued in Florida and specified whether the insurer surcharged HIPAA-eligible individuals above standard rates. Since rates charged by insurers issuing out-of-state policies are not required to be filed, the department conducted a telephone survey of insurers and obtained information from 5 of the 27 insurers identified as issuing certificates in the state under out-of-state policies, specifying the extent to which surcharges are imposed on HIPAA-eligible individuals. Information was also obtained from the department regarding complaints regarding access to guaranteed-issue coverage. Interviews were also conducted with insurance representatives.

FINDINGS

Reports by the U.S. General Accounting Office

On September 2, 1997, the U.S. General Accounting Office (GAO) issued a memorandum on the subject of early HIPAA implementation concerns. (GAO/HEHS-97-200R) The report stated that premiums for some guarantee-issue products (also referred to as "portability products") may be substantially higher than for standard products. Of the five different carriers whose rates they reviewed, one charged the standard rate to HIPAA eligibles and the remainder charged or anticipated charging 29, 40, 85, and 125 percent above the standard rate.

The GAO report found that in addition to initially higher rates, the way many carriers determine future premium rates for portability products will further increase the discrepancy with standard premiums. Some carriers place HIPAA eligibles into separate rating pools, where the expected higher claims costs could result in higher premiums. Further, some carriers permit HIPAA eligibles to apply for both the portability product and a lower cost standard product. If individuals are healthy enough to pass medical underwriting, they become eligible for the standard product. If unhealthy, they are enrolled in the portability product, which could result in an increasing spiral of poorer risks and higher premiums, as reported by the GAO.

In response to the initial GAO findings, carrier officials stated that segregating HIPAA eligibles and charging higher premiums was necessary to prevent the remainder of the individual market from subsidizing HIPAA eligibles through higher premiums. Another carrier response was that it would be unfair to deny the opportunity for a healthy HIPAA eligible to enroll in a standard product. It was further pointed out that there was nothing in the HIPAA act or regulations that prohibited these rating practices.

A follow-up report by the GAO to the Senate committee was issued in February 1998. (GAO/HEHS 98-67) The GAO focused on the 13 states that use the federal fallback approach which requires all carriers in the individual market to offer eligible individuals at least two health plans. The GAO found that carrier marketing activities attempted to discourage consumers from applying for guaranteed-issue products and that the rates charged by nine individual market carriers in the three fallback states they visited (Arizona, Colorado, and Missouri) ranged from 140 to 400 percent of the standard rate. Anecdotal evidence from insurance regulators and agents indicated that rates were as high as 600 percent of the standard rate. The GAO also found that these carriers typically evaluate the health status of applicants and offer healthy individuals the option of buying a standard product which may cost considerably less than the HIPAA product. Unhealthy HIPAA-eligible individuals may have access only to the guaranteed access product, and some of them may be charged an even higher premium on the basis of their health status.

The GAO concluded that among the 13 federal fallback states, some consumers were finding it difficult as a result of high premiums to obtain the guaranteed-access coverage that HIPAA requires. This situation was likely to continue, according to the GAO, unless the federal agency charged with enforcement and implementation, the Department of Health and Human Services (HHS), interprets HIPAA to provide for more explicit risk-spreading requirements or states adopt explicit risk-spreading requirements of guaranteed access to coverage for HIPAA eligibles.

Actions by the Florida Department of Insurance

The Florida Department of Insurance (DOI) issued a bulletin to health insurers and HMOs on October 7, 1997, stating the department's position with regard to rates charged for coverage to HIPAA-eligible individuals: "Eligible individuals must be offered these policy forms at the rate of the most predominately sold premium class if different premium classes are sold." The department interpreted the statutory requirement that insurers and HMOs offer their two most popular policy forms to HIPAA-eligible individuals as incorporating a requirement that these forms be at the rate of the most predominately sold premium class. This interpretation is being challenged in an administrative hearing by an insurer at the time of this report.

In a subsequent bulletin issued on April 30, 1998, the department sent all health insurers and HMOs a copy of Program Memorandum #98-01 from the Health Care Financing Administration, U.S. Department of Health and Human Services, which raised concerns about the practice of "rating up" the premiums for HIPAA-eligible individuals. The HCFA memo stated:

> [W]e have been notified that some issuers may be offering coverage to HIPAA-protected individuals at rates well in excess of the general industry maximum in place before HIPAA of 200 percent of standard risk -- in fact, reports indicate premium rates as high as 500 to 600 percent of standard risk. This practice of establishing rates to exclude HIPAA-protected persons is known as "rating up." We have been advised that issuers may be intentionally offering coverage at unaffordable rates, in order to avoid providing coverage to HIPAA-eligible individuals and small groups while appearing to comply with the guaranteed availability provisions of HIPAA. We are continuing to gather information about this problem.

Questions and complaints from HIPAA-eligible consumers alerted the Florida DOI to examples of insurers surcharging or "rating up." Specific examples provided to committee staff included four persons who were offered coverage at a rate 500 percent above the insurer's standard rates, two persons who were offered coverage at 200 percent above the standard rate, and one example which department records merely refer to as a "large increase."

Rates Charged to HIPAA-Eligibles by Florida Insurers

Only four insurers have been identified by the Florida Department of Insurance as currently issuing individual major medical health insurance policies in Florida. An additional 11 health maintenance organizations are identified as issuing individual HMO contracts in the state within their respective geographical service areas. In addition, 27 other insurers have been identified as issuing individual certificates in Florida under group policies issued outside the state.

The department provided information regarding the premium rates charged to HIPAA-eligible individuals by three of the four insurers identified as issuing individual health insurance policies in Florida. Two of these insurers did not impose any surcharge on

HIPAA-eligible individuals. However, the current rate manual on file for one of these two insurers provides for a maximum 300 percent surcharge, but the insurer is not using these rates pursuant to its agreement with the department. The third insurer has sent notice to its agents of its intent to surcharge HIPAA-eligible individuals as high as 300 percent above standard rates, but the insurer's rate manual filed with the department provides for a maximum 125 percent surcharge. The insurer's rates are currently the subject of an administrative action between the department and this insurer.

None of the 10 health maintenance organizations issuing individual contracts in Florida for which the department provided rate information is currently surcharging HIPAA-eligible individuals. One of these HMOs requested a 100 percent surcharge for HIPAA-eligibles, but the HMO is not imposing this surcharge pursuant to its agreement with the department.

Some insurers issuing individual coverage in Florida under out-of-state group policies are surcharging individuals due to HIPAA-eligibility status or due to medical underwriting, or both. The department was able to obtain rates from 5 of the 27 insurers identified as issuing individual coverage under out-of-state group policies. Only one of these insurers indicated that it was not surcharging HIPAA-eligible individuals. Two of the insurers imposed a maximum 100 percent surcharge --one insurer imposing the surcharge due to HIPAA-eligibility status alone, and the other insurer imposing a 40 percent surcharge due to HIPAA-eligibility status plus a 60 percent surcharge due to medical underwriting. Another insurer imposed a maximum 200 percent surcharge, with half of the surcharge based on HIPAA-eligibility (100 percent surcharge) and half based on medical underwriting (100 percent surcharge). The fifth insurer imposed a 10 percent surcharge for certain specified occupations.

As indicated above, premium rates for individual coverage charged by health insurers and health maintenance organizations for policies and contracts *issued in Florida* generally do not surcharge HIPAA-eligible individuals based on their eligibility or health status. This is apparently due to the department's bulletin and subsequent actions to enforce their interpretation of current law as not allowing insurers to surcharge HIPAA-eligible individuals above the rate of the most predominately sold premium class. As noted, two insurers and one HMO have attempted to impose surcharges ranging from 100 percent to 300 percent, but department actions have thus far prevented their implementation.

However, rates charged to HIPAA-eligibles are subject to surcharges by some insurers issuing individual coverage under *out-of-state group policies*. Of the five insurers responding to the survey, one insurer imposes surcharges up to 200 percent above standard rates and two insurers impose surcharges up to 100 percent above standard rates based on HIPAA-eligibility or medical underwriting. Under current Florida law, rates for out-of-state group policies are not subject to regulation by the department, so the department's opinion as to the legal prohibition of surcharging HIPAA-eligibles has no bearing on out-of-state group policies.

Risk-Spreading Options

It is argued that charging rates that are adequate to cover expected claims costs for health conditions identified through medical underwriting is necessary to prevent premiums from increasing for healthy individuals. Such increases will prevent or discourage healthy individuals from buying health insurance which further worsens the claims experience of an insured's book of business and drives rates upward.

The main argument against allowing carriers to surcharge HIPAA-eligibles is that coverage becomes unaffordable to many persons and frustrates the spirit and intent of the law to enable previously insured persons to maintain coverage. The U.S. General Accounting Office report cited above concluded that high premiums were making it difficult for consumers to obtain guaranteed-access coverage and that this situation was likely to continue unless more explicit risk-spreading requirements were imposed. The Health Care Financing Administration, charged with enforcement of HIPAA, has published similar concerns as cited above.

The argument that risk-spreading will increase standard premiums for healthy risks is valid, but there is disagreement as to how much of an increase will result. Prior to enactment of HIPAA, the Health Insurance Association of American (HIAA) estimated that the proposed legislation would increase premiums for those currently buying individual health insurance by about 22 percent. This was based on an assumption that individuals purchasing portability coverage would have claims double those of individuals currently purchasing individual health insurance policies and that such higher

costs would be spread evenly over all participants in the individual health insurance market (among various other assumptions). A subsequent report by the Rand Corporation found a much smaller increase, estimating a range of 1 percent to 5.7 percent, with a best estimate of 2.3 percent. The upper end of the range was based on the same assumption used by HIAA of pooling costs between those currently purchasing individual insurance and the new portability policies. The lower end of the range was based on Rand's assumption that state insurance regulations would generally permit insurers to have separate rating pools. The Rand report differed with the HIAA assumption of claims costs, with Rand assuming that claim costs for portability policies would be similar to the claim costs for people currently insured under COBRA. The Rand report also noted that since the individual health insurance market has had recent premium increases well over 5 percent per year, the long-run effect of the legislation would likely be undetectable.

The number of HIPAA-eligible policies issued in Florida is not reported to the Department of Insurance, but indications are that the amount is relatively small. The largest writer of individual policies in the state, Blue Cross Blue Shield of Florida, reports that it has issued 311 policies to HIPAA-eligible individuals, with 40 applications pending as of October 12, 1998.

Florida has established a reinsurance program that offers individual carriers the opportunity to mitigate their losses for HIPAA-eligible individuals expected to generate claims costs well in excess of premiums. A reinsurance program established in 1992 for small group carriers was expanded in 1997 to cover individual carriers for policies issued to HIPAA-eligibles. Individual carriers must make an election to either participate in the program as a *reinsuring carrier* or be a nonparticipating *risk-assuming carrier*. As a reinsuring carrier, the insurer or HMO may purchase reinsurance coverage for identified high-risk individuals and be reimbursed for a specified percentage of their claims costs. A reinsuring carrier is also liable for limited assessments to fund deficits incurred by the reinsurance pool. Alternatively, as a risk-assuming carrier, the carrier is solely responsible for assuming the liability of claims costs for all policies it issues to HIPAA-eligible individuals, but the carrier is not liable for any assessments incurred by the reinsurance pool.

Of the 43 total number of individual carriers in Florida (including insurers issuing certificates under out-of-state group policies), 27 have elected to be risk-assuming carriers and 16 have elected to be reinsuring carriers. To date, only two individual risks have been reinsured with the reinsurance pool, not including the one-life groups (self-employed individuals) reinsured under the small group program. A carrier is required to pay a reinsurance premium equal to five times the standard rate established by the board of the reinsurance pool. The reinsuring carrier retains liability for the first $5,000 of claims in a calendar year, 10 percent of the next $50,000, and 5 percent of the next $100,000 of claims, (i.e., $15,000 maximum retained liability annually) and the reinsurance program covers all claims costs in excess of $155,000. In the event of a deficit in the individual reinsurance account, reinsuring carriers may be assessed up to 5 percent of premiums for individual health insurance policies written in Florida. If a deficit still remains, all health insurance carriers (except individual reinsuring carriers) may be assessed up to 0.5 percent of premiums for all health benefit plans issued in Florida.

Some carriers have commented that the reinsurance pool does not provide an adequate risk-spreading mechanism. The combination of a substantial reinsurance premium plus retained liability for up to $15,000 of annual claims costs makes the reinsurance a viable option only for the highest cost cases. Also, the first-tier assessment of 5 percent of premiums imposed on reinsuring carriers (of which there are only 16, currently) is a much greater financial burden than the second-tier assessment of 0.5 percent of premiums against all other health benefit plans issued in Florida. The second-tier assessment potentially spreads the costs of HIPAA-eligible individuals to carriers in the group insurance market, which have a much broader base of insureds, but the current method may not effectively achieve this result.

Some carriers and others advocate a high-risk insurance pool, like the Florida Comprehensive Health Association (FCHA), as the preferred method of guaranteeing access to individual coverage, which is used in 26 states. The FCHA previously issued coverage to individuals unable to obtain coverage in the private market, but due to funding concerns was prohibited from writing new coverage as of July 1, 1991. It has continued to renew coverage and currently insures about 1,000 individuals. The FCHA is funded by charging premiums capped at 200 percent, 225 percent, and 250 percent of the standard risk rate (a statewide average rate) for low, medium, and high risk individuals, respectively, and by assessing all health insurance carriers up to a maximum

of 1 percent of health insurance premiums written in Florida. In 1997, the average annual premium for a FCHA policyholder was $3,531 and the deficit assessment (not yet billed to carriers) is estimated at $1.9 million.

Reasons given in 1997 for choosing a guarantee-issue approach versus a high-risk pool approach for HIPAA-eligible individuals included a desire to pool all individual insureds in the private insurance market rather than segregate the insuring of high-risk individuals in a state-created association. It was also noted that guaranty-issue was the preferred federal fallback method under HIPAA. While it was recognized that a high-risk pool provides a risk-spreading mechanism by assessing all carriers an equal percentage, it was asserted that an individual reinsurance pool would also serve this function. However, the cost allocations of the reinsurance pool may prevent it from effectively spreading risk among carriers, as indicated by its limited use to date. Even though department actions have effectively required carriers to spread risk within an individual carrier's book of business, by prohibiting premium surcharges on HIPAA-eligible individuals, it is questionable whether the department will be able to maintain and enforce this interpretation of the current law.

RECOMMENDATIONS

The Legislature should consider the following:

1. ***Prohibit carriers issuing individual coverage from surcharging individuals based on HIPAA-eligibility status alone.--*** The fact that an individual is eligible under HIPAA for guaranteed issuance of coverage should not be the sole reason used to increase premiums. It is unfairly discriminatory to place an individual in a higher-rated classification based on this fact alone, without any other objective, health-related reason for doing so. If surcharging is allowed, it should be based on medical information or other risk factors affecting health which indicate that the individual is likely to generate claims in excess of standard risks.

2. ***Limit premium surcharges to 50 percent above standard rates for premiums charged by individual carriers to HIPAA-eligible individuals based on medical underwriting.--*** Pricing individual policies for HIPAA-eligible individuals substantially above standard rates, based on medical underwriting, makes such policies unaffordable to many persons and frustrates the intent of guarantee-issue reforms. However, disallowing any surcharge for nonstandard risks will tend to increase premiums for all policyholders and will discourage healthy individuals from purchasing coverage. Limiting the amount of a surcharge may be the most appropriate way to balance affordability for all parties.

3. ***Apply any limitation on premiums for HIPAA-eligible individuals to carriers issuing out-of-state polices covering Florida residents.--*** Any restriction that is placed on surcharging HIPAA-eligible individuals will not have its intended effect if it is limited to policies issued in Florida and not applied to individual certificates issued in Florida under an out-of-state group policy. There is virtually no distinction between the way these two products are marketed to individuals in the state and most persons are unaware of the different legal consequences, despite certain disclosure language that must appear on the policy. Many more insurers sell individual coverage in the state under out-of-state group policies rather than true individual policies, as a way to exempt themselves from rate regulation and many of the mandated benefits that apply to in-state policies. HIPAA-eligible individuals will continue to be subject to surcharges of 100 percent, 200 percent, or more if a lower limit does not universally apply to all individual coverage sold in the state.

4. ***Restructure the individual reinsurance pool to lower costs to reinsuring carriers and to spread costs more evenly over the statewide health insurance market.--*** The current individual reinsurance pool does not provide a viable option for reinsuring carriers to mitigate losses, except for the most serious, high-risk cases. The current premium to reinsure any one risk is set at 5 times the standard rate, as established by the reinsurance board, plus the reinsuring carrier remains liable for up to $15,000 in claims costs per year. As a group, reinsuring carriers are additionally liable for assessments up to 5 percent of their written premium for individual coverage in the state. Only after these costs are assessed are other health insurance carriers liable for any remaining deficit in the reinsurance pool and that liability is limited to 0.5 percent of written premiums for all health benefit plans issued in the state. Restructuring this risk-spreading mechanism to the benefit of reinsuring carriers would limit the pressure on such carriers to increase their standard rates for individual coverage, particularly if a cap is placed on surcharging

HIPAA-eligibles. For example, the reinsurance premium could be lowered to three times the standard premium or, possibly three times the premium that the reinsuring carrier is charging the individual. In order to provide for risk-spreading to a much broader base, the first-tier assessment against reinsuring carriers could be reduced from 5 percent to 3 percent and the second-tier assessment against all health insurance carriers could be increased from 0.5 percent to 1 percent. Or, only one level of assessments could be imposed on all health insurance carriers equally, as the Florida Comprehensive Health Association is currently funded, by a maximum 1 percent assessment on all health benefit plans issued in the state. Individual risk-assuming carriers should continue to be exempt from any assessments, since they have elected to assume all costs for the policies they issue to HIPAA-eligible individuals.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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MEMBER OVERSIGHT
Senators Betty S. Holzendorf and Howard C. Forman