

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL: SB 1128

INTRODUCER: Health Policy Committee

SUBJECT: Health Flex Plans

DATE: April 7, 2013

REVISED: _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|----|---------|----------------|-----------|---------------------------------|
| 1. | Lloyd | Stovall | | hp SB 7014 as introduced |
| 2. | Johnson | Burgess | BI | Pre-meeting |
| 3. | | | CA | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

I. Summary:

SB 1128 extends the termination date of the Health Flex program to January 1, 2014, or upon the availability of qualified health plans through an exchange, whichever occurs later. Without legislative action, the Health Flex program will sunset on July 1, 2013.

This bill substantially amends section 408.909, Florida Statutes.

II. Present Situation:

The Health Flex program was created by the 2002 Legislature to address the health insurance needs of Florida's lower income uninsured adult population.¹ At the time, Florida's uninsured rate was reported as 16.8 percent, or 2.1 million while for those under 150 percent of the federal poverty level (FPL) the rate was reported at 34 percent.² Initially launched as a pilot program limited to three areas of the state with the highest incidences of uninsured adults and Indian River County, the program had an original expiration date of July 2004.³

Subsequent legislative acts removed the limited geographic reach of the project extending the scope statewide as well as modified the expiration date multiple times until it reached its current

¹ SB 46-E (2003-E Session).

² Analysis for SB 46-E by the Senate Committee on Health, Aging and Long Term Care (April. 30, 2002), available at <http://archive.flsenate.gov/data/session/2002E/Senate/bills/analysis/pdf/2002s0046E.hc.pdf> (last visited Feb. 11, 2013).

³ Id.

expiration date of June 30, 2013.⁴ Plans are currently available in six counties: Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie.⁵

The enacting legislation's intent emphasized alternative approaches for affordable health care options over traditional insurance coverage for the uninsured. Products offered as health flex plans were to include basic and preventive health care services and to coordinate with local service programs.⁶

Health Flex plans can be offered through a variety of means, including by licensed insurers, health maintenance organizations (HMOs), health care providers, local governments, health care districts or other public or private organizations.⁷ Products sold under the program are not subject to the Florida Insurance Code.⁸ As of September 30, 2012, three plans cover 12,127 members.⁹

| Plan Name | Enrollment – September 30, 2012 |
|------------------------------|---------------------------------|
| American Care, Inc. | 347 |
| Preferred Medical Plan, Inc. | 1,630 |
| Vita Health Plan, Inc. | 10,150 |
| Total Enrollment: | 12,127 |

Eligibility for the program has also been modified multiple times since inception. Today, an individual must meet the following requirements:¹⁰

- Be a resident of the state;
- Have a family income equal to or less than 300 percent FPL (\$69,150 for a family of four based on 2012 federal guidelines);
- Not be covered by a private insurance policy and not be eligible for public coverage such as Medicare, Medicaid, or KidCare, or have not been covered at anytime in the last 6 months;
- Have applied for health care coverage through an approved Health Flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or,
- Be part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the Health Flex plan entity is a health insurer, health plan or HMO, only 50 percent of the employees must meet the income requirement.

In addition, if a person did have coverage in the past 6 months under an individual health maintenance organization (HMO) contract licensed in the Florida which was also a licensed

⁴See Chapter Law 2003-405, Chapter Law 2004-270, Chapter Law 2005-231, Chapter Law 2008-32, Chapter Law 2011-195.

⁵Florida Agency for Health Care Administration and Florida Office of Insurance Regulation, *Health Flex Plan Program, Annual Report*, 3-5, (January 2013).

⁶SB 46-E (2003-E Session).

⁷s. 408.909(1), F.S.

⁸s. 408.909(4), F.S., *supra* at n. 2.

⁹*Supra*, note 5 at 5-6.

¹⁰*Supra*, note 5, at p. 2-3.

Health Flex plan on October 1, 2008, the individual may apply for coverage under that same Health Flex plan without a lapse in coverage if all other eligibility requirements are met. If a person was covered under Medicaid or KidCare and lost eligibility for Medicaid or KidCare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan, the individual may apply for coverage in a Health Flex plan without a lapse in coverage if all other eligibility requirements are met.

Responsibility for the Health Flex program resides with both the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (OIR). The Agency and the OIR jointly review applications for health flex plans, develop necessary rules, evaluate the program, and produce an annual report. The Agency has primary responsibility for reviewing health flex applications and determining whether plans meet quality of care standards and follow standard grievance procedures. The OIR is responsible for monitoring the financial condition of each plan.

In March 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).¹¹ Beginning January 1, 2014, the federal government and some states plan to launch one of the largest components of the PPACA legislation, health benefits exchanges.¹² The exchange implementation coincides with the requirement that, with few exceptions, all individuals must maintain a minimum level of health insurance coverage for themselves and their dependants.¹³ New subsidies, advanced premium tax credits, and out of pocket cost sharing maximums become effective at the same time to assist lower income enrollees with the cost of that coverage.¹⁴ These premium assistance measures assist individuals at varying levels from 100 percent FPL up to 400 percent FPL (\$45,960 for an individual in 2013).¹⁵

Health care coverage will be available through Medicaid or the Children's Health Insurance Program (CHIP) for the lowest income individuals. Children are covered under Medicaid or CHIP in Florida currently up to 200 percent FPL.¹⁶ The state may also elect to extend Medicaid eligibility to adults up to 133 percent FPL.^{17, 18}

Under PPACA, a state may operate its own exchange, partner with the federal government or default to a federal exchange.¹⁹ Regardless of the option selected by a state, individuals will have a choice of qualified health plans that meet established standards and offer the minimum set of

¹¹Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).

¹²*Id.*

¹³Hinda Chaikind, *Individual Mandate and Related Information Requirements under PPACA*, Congressional Research Service, 1, (September 21, 2010), http://www.ncsl.org/documents/health/Individual_Mandate_Under_PPACA.pdf, (last visited Feb. 11, 2013).

¹⁴Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (July 2012), <http://www.kff.org/healthreform/upload/7962-02.pdf> (last visited Feb. 13, 2013).

¹⁵78 FR 5182 (5182-5183), January 24, 2013.

¹⁶State of Florida, Florida KidCare Program, Title XXI State Plan, *Amendment #22, (5)*, http://www.fdhc.state.fl.us/medicaid/medikids/PDF/KidCare_Program_Amendment_21_to_Title_XXI_2012-07-01.pdf, (last visited Feb. 11, 2013).

¹⁷*Supra*, Note 10.

¹⁸*National Federation of Independent Business (NFIB) et al v. Sebelius*, 567 U.S., ___(2012).

¹⁹Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *General Guidance on Federally-facilitated Exchanges*, (May 16, 2012), <http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf> (last visited Feb. 11, 2013).

essential health benefits. In order to be offered on the exchanges, a health plan has to offer the benefits in ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.²⁰

The essential health benefits requirement does not apply to all plans, including certain current self-insured group plans, health insurance coverage offered in the large group market, and grandfathered health plans. Individuals that do not maintain coverage that meets the PPACA minimum requirements and cannot show a hardship or meet some other allowable exemption, will be subject to a penalty.²¹ To qualify for the hardship exemption, an individual who is not eligible for Medicaid and who is above the filing threshold for income taxes must show that the cost of his or her contribution towards self-only coverage for a calendar year will exceed 8 percent of household income.²²

Under the federal definitions of health insurance coverage and health insurance issuer, coverage includes medical and hospital benefits that are offered by an issuer licensed in the state and whose coverage is regulated by that state.²³ Some health coverage may also meet the definition of excepted benefits, which would not qualify as minimum essential coverage for the individual mandate.²⁴ Examples of excepted benefits would include coverage limited to dental or on-site medical clinics.²⁵

Under s. 408.909(4), F.S., the Health Flex plans are not currently subject to all of the Florida Insurance Code and are not considered an insurance product. The plans are not required to cover Florida's mandated benefits or meet solvency requirements. Neither do the current benefits schedules of the Health Flex plans comply with the essential health coverage as the packages do not incorporate all ten essential health benefit categories based on a review of the web based marketing materials for the three plans.²⁶

III. Effect of Proposed Changes:

The bill extends the expiration date for Health Flex plans from June 30, 2013, to January 1, 2014, or upon availability of qualified health plans through an exchange, whichever occurs later. The January 1, 2014, date extension corresponds to the implementation date of the major components of the Patient Protection and Affordable Care Act (PPACA) relating to exchanges and the individual mandate for insurance coverage.

²⁰ Healthcare.gov., <http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html>, (last visited Feb. 11, 2013).

²¹ Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).

²² Chaikind, *supra* Note 13 at 3.

²³ 42 U.S.C. s.300gg-91(b).

²⁴ Chaikind, *supra* note 13, at 1-2.

²⁵ 42 U.S.C. s. 300gg-91(c)

²⁶ Websites for three Health Flex plans reviewed on February 12, 2013: American Care Plans, *Health Flex Plans*, <http://www.healthflex.org/files/HealthFlexBrochure.pdf>, Preferred Medical Plan, Medi-Flex Plan, <https://www.pmphmo.com/plans.php>, and Vita Health Plan, <http://www.vitahealth.org/index.aspx?page=453>, (last visited Feb. 11, 2013).

Given that varying levels of subsidies, advance payment of premium tax credits and other cost sharing limitations are available for individuals up to 400 percent FPL and those served by the Health Flex program are under 300 percent FPL, coverage options would be available for most individuals currently under the Health Flex program in the exchange. However, individuals under 100 FPL would not be eligible for subsidies through an exchange.

Other Potential Implications:

Open enrollment for the exchanges begins October 1, 2013, for January 1, 2014, enrollment. Participants in the Health Flex program should be given ample notice by their respective plan of the impending termination of their coverage to allow sufficient application and transition time to other coverage.

Should Florida elect not to expand Medicaid for adults to 133 percent FPL, there would be a gap in subsidized coverage options for individuals under 100 percent FPL.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector employers may participate in the Health Flex program and can contribute towards the cost of their employees' health coverage. Other options for contributing towards the cost of employees' health coverage will be available in the exchange.

With the termination of the Health Flex program, enrollees above 100 percent FPL would likely transition into the exchanges to access premium subsidies or Medicaid, if Florida extends eligibility to the adult population, as appropriate to their income level.

C. Government Sector Impact:

One plan, Vita offered by the Health Care District of Palm Beach County, offsets the cost of coverage. The Health Care District currently subsidizes approximately two thirds of the total premium with the enrollee paying the remaining one third of the total premium.²⁷ Upon termination of this program, the District would be able to redirect these funds.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The exchanges under PPACA are scheduled to hold their first open enrollment period starting October 1, 2013, for effective dates as early as January 1, 2014. The Agency, OIR and the Health Care District of Palm Beach County which is the plan with the largest Health Flex plan enrollment, have expressed concern as to whether or not existing Health Flex plan members will successfully transition during the inaugural open enrollment period. These entities have suggested an additional extension beyond January 1, 2014, may be necessary to ensure enrollees have sufficient time to find other coverage.

VIII. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

²⁷*Supra*, Note 5, at 6.