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DATE: March 30, 1998

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 4495

RELATING TO: Health Insurance

SPONSOR(S): Committee on Health Care Services, Rep. Albright & others

COMPANION BILL(S): None

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

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I. SUMMARY:

HB 4495 is designed to correct several “glitches” which occurred as a result of the enactment of CS/SB 1682, which placed into Florida law, the provisions of the federal “Health Care Portability and Accountability Act of 1996" (HIPAA). In this regard, this bill does the following three things:

- Conforms Florida law on group health insurance conversion requirements to the provisions of HIPAA specifically related to renewability.

- Incorporates the provisions of the federal “Mental Health Parity Act of 1996" into the Florida Insurance Code.

- Clarifies which provisions of Florida’s Long-Term Care Insurance Act apply to limited benefit policies, adds a disclosure statement for limited benefit policies, and conforms the definition of “preexisting condition” for long-term care policies to HIPAA.

In addition, this bill: exempts from legal process, garnishment or attachment moneys paid into or out of a Medical Savings account; reinstates an exemption from licensure under chapter 395, F.S., (which regulates hospitals) for certain beds of a health maintenance organization (the exemption was inadvertently repealed in a 1996 law.); requires health insurance policies and health maintenance contracts to provide coverage for prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by an authorized practitioner; revises minimum standards for Medicare supplement policies to conform to federal law; exempts policies which provide for expanded coverage, written in conjunction with comprehensive medical policies, from the requirements of the small group law (s. 627.6699, F.S.); increases minimum surplus requirements and insolvency protection standards for HMOs; and requires reporting of adverse incidents to DOI by certain providers who obtain professional liability insurance through the Board of Regents.

The fiscal impact on the state for state employee health benefits for employees and dependents in the self-insurance plan related to the “Federal Mental Health Parity Act of 1996" is estimated to be $3 million in fiscal year 1998-99. The fiscal impact of this provision on local governments is indeterminate, as is the fiscal impact on state and local

governments of the coverage requirements for prescription oral contraceptives. The remainder of the bill has no fiscal impact on state or local government.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

HIPAA--During the 1997 Session of the Legislature, CS/SB 1682 was enacted into law (Ch. 97-179, Laws of Florida). The purpose of this law was to conform the Florida Insurance Code to the provisions of the federal "Health Insurance Portability and Accountability Act of 1996" (HIPAA). HIPAA requires, effective July 1, 1997, that any person with 18 months of creditable coverage, who does not have access to other specified health insurance, must be given access to an insurance policy. Creditable coverage is defined to include any of the following: a group health plan, individual health insurance, Medicare, Medicaid, the Florida Comprehensive Health Association, and others. However, the last period of creditable coverage must have been under a group health plan.

Federal law permits states to adopt an "acceptable alternative mechanism" for access to health insurance of HIPAA eligibles, which must be approved by HCFA. CS/SB 1682 creates this alternative mechanism as follows:

- For HIPAA eligibles who have access to a conversion policy, the policy serves as access to an insurance policy.
- Insurers offering a conversion policy must offer at least two different policy forms (standard and basic or equivalent).
- The premium rate on HMO conversion policies is capped at 200% of the standard risk rate. (Conversion policies offered by insurers are already capped at this rate.)
- All other HIPAA eligibles must be given access to an individual health insurance policy by any insurer selling individual policies in Florida. Again, at least two policy forms must be offered.
- A "reinsurance pool" is created for individual insurers who wish to reinsure HIPAA eligibles. The pool is closely modeled on the small group reinsurance pool.
- Reinsuring individual health insurers, and then all health insurers (excluding risk assuming carriers) are subject to assessments to fund the reinsurance pool.

In addition, the CS/SB 1682 conformed the Florida Insurance Code to the provisions of HIPAA for individual, group, small group, and HMO policies.

Conversion Policies--Employees and dependents covered under a group health insurance policy may, pursuant to s. 627.6675, F.S., obtain a conversion policy if their eligibility under the group health plan terminates for any reason except for the failure to pay premiums or replacement by an alternative health plan within 63 days of discontinuance of the group coverage. This right to a conversion policy is interpreted as applying at the end of the period of time that the individual elects to continue the group coverage under COBRA or the state continuation law.

Under a conversion policy, group carriers are required to offer the standard policy required to be offered to small employers under s. 627.6699, F.S. The maximum premium for the conversion policy is 200 percent of the "standard risk rate" as developed by the Florida Comprehensive Health Association. The standard risk rate is based on the average rate for individual health insurance and would likely be higher than group rates.

Section 641.3922, F.S., requires an HMO to offer a conversion contract to employees and dependents with a level of benefits similar for those services included in the group HMO contract from which the termination was made, or to offer the standard policy required to be offered to small employers under s. 627.6699, F.S. The same premium cap of 200 percent of the standard risk rate (applicable for converted group insurance policies) applies to an HMO conversion contract.

Conversion policies are required by Florida law (s. 627.6675, F.S.) to be guaranteed renewable, unless certain conditions exist, including:

- Fraud or material misrepresentation in applying for any benefits under the converted policy.

- Eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

Federal law (HIPAA) requires that policies be guaranteed renewable unless similar conditions exist, except, federal law substitutes the word “intentional” for the word “material” in item A, and federal law does not except item B as a reason for nonrenewal. Therefore, Florida law is currently inconsistent with federal law with regard to guaranteed renewability for HIPAA eligible persons.

Long-term Care Insurance Policies--Florida's Long-Term Care Insurance Act, enacted in 1988, establishes minimum requirements for the content and sale of long-term care insurance. As specified in the purpose section of the Act (s. 627.9402, F.S.), the Legislature sought to protect consumers from unfair trade practices, to facilitate the public's understanding and comparison of long-term care policies, and to provide a climate of flexibility and innovation for the development of long-term care coverage.

Long-term care is generally considered to be assistance with daily living activities for individuals who, because of a physical or mental disability, are unable to function independently. Long-term care ranges from non-medical support services provided in a person's home to intensive medical services and continuous monitoring provided in a skilled nursing facility. As defined in the Long-Term Care Insurance Act, "long-term care insurance" means any insurance policy that provides coverage for "one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital" subject to specified exceptions (s. 627.9404, F.S.) .

In addition to other minimum standards, the Long-Term Care Insurance Act requires a long-term care policy to provide coverage for at least two years for care in a nursing home, and (as further specified by department rule) for at least one year for a lower level of care, such as home health care or adult day care.

The HIPAA establishes a federally qualified long-term care insurance policy which qualifies for favorable tax treatment in certain circumstances. The policy conditions and coverages, including benefit triggers, of this policy are specifically addressed in the federal act. These policies were authorized effective January 1, 1997. In 1996, the Legislature passed amendments to “The Long-Term Care Insurance Act”, in Chapter 96-275, Laws of Florida. This law establishes specific benefit triggers for long-term care insurance policies sold in Florida effective July 1, 1997. These benefit triggers are more

"consumer friendly" than the benefit triggers in the federal law. The federal benefit triggers differ from the Florida triggers in the following ways:

1. The federal trigger conditions the payment of benefits on the inability of the insured to perform at least two activities of daily living without assistance. The Florida trigger conditions the payment of benefits on the inability to perform not more than three activities of daily living without assistance.

2. The federal trigger further conditions the payment of benefits on the insured being chronically ill which is defined as being unable to perform at least two activities of daily living for at least 90 days. The Florida trigger contains no such requirement.

In addition to differences between state and federal law relating to long-term care insurance benefit triggers, there are also differences in the services which must be covered under a policy. State law requires that in order to be designated a “long-term care insurance policy” the policy must provide coverage for care in a nursing home and may not restrict its coverage to care only in a nursing home (see s. 627.9407(3), F.S.). Federal law permits long-term care insurance policies to limit care to a nursing home only. Policies sold in Florida which restrict care to a nursing home or provide only limited benefits like home health care are designated “limited benefit policies”. In Florida, both long-term care policies and limited benefit policies may qualify for favorable federal tax treatment if either policy meets the requirements of s. 7702B of the Internal Revenue Code. Such policies are referred to as “qualified long-term care policies” or “qualified limited benefit policies”.

Mental Health

On September 26, 1996, the Federal Mental Health Parity Act of 1996 (MHPA) was signed into law, and provides for parity in the application of limits for certain mental health benefits. These limits include:

- Aggregate Lifetime Limits--Where a group health plan (or health insurance offered in connection with such a plan) provides both medical and surgical benefits, and mental health benefits:

  No Lifetime Limits. Such plan or coverage may not impose any aggregate lifetime limits on mental health benefits if it does not include such an aggregate lifetime limit on substantially all of its medical and surgical benefits.

  Lifetime Limits. If such a plan or coverage does include an aggregate lifetime limit on substantially all of its medical and surgical benefits, the plan or coverage shall either:

  -- Apply its applicable lifetime limits both to medical and surgical benefits, and to mental health benefits without distinction in the application of the limits between these categories of benefits; or

  -- Not include any aggregate lifetime limit on mental health benefits that is less than the plan’s applicable lifetime limit for substantially all of its medical and surgical benefits.

Different Limits. In the case of a plan or coverage that is not described above and that includes no or different aggregate lifetime limits for different categories of medical and surgical benefits, regulations shall establish rules that calculate an average aggregate lifetime limit for mental health benefits.

- Annual Limits--

No Limits. Similarly, in the case of a group health plan providing both medical and surgical benefits and mental health benefits, a plan which does not include annual limits on all of its medical and surgical benefits may not impose any annual limit on mental health benefits.

Annual Limits. A plan which imposes annual limits on its medical and surgical benefits may either:

-- Apply the applicable annual limit without distinction to both its medical and surgical benefits and its mental health benefits; or

-- Not include any annual limit on mental health benefits that is less than the applicable annual limit for any other benefits.

Different Limits. In the case of plans which have no or different annual limits on different categories of medical and surgical benefits, regulations shall establish rules that calculate an average annual limit for mental health benefits.

- Exemptions--

Small Employer Exemption. The new law does not apply to any plan or coverage of any employer who employed between 2 and 50 employees during the preceding calendar year, and who employed less than 2 employees on the first day of the plan year.

Increased Cost Exemption. This mental health parity provision shall not apply to a group health plan if the application of the new provision results in an increase in cost of at least 1% under the plan or coverage.

- Separate Application to Each Option Offered--In the case of a plan that offers a participant or beneficiary two or more benefit packages under the plan, the statutory provisions shall be applied separately with respect to each option.

- Construction--

-- The new law does not require any plan or coverage to provide any mental health benefits.

-- The new law does not affect any existing terms or conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration or scope of mental health benefits under such plans, except as specifically provided regarding parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

-- The new legislation also does not apply to benefits for substance abuse or chemical dependency.

- Effective Date--

  -- The MHPA applies to group health plans beginning on or after January 1, 1998.

  -- Under a so-called “sunset” provision, the MHPA requirements do not apply to benefits received on or after September 30, 2001.

  - There is no separate effective date for collectively bargained plans.

Florida Law--Section 627.668, F.S., relates to optional coverage for mental and nervous disorders. This law requires every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting group health insurance or providing prepaid health care in this state to make available to the policyholder as part of the application, for an appropriate additional premium, benefits for the necessary care and treatment of mental and nervous disorders.

Under group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may not be less favorable for mental health than for physical illness generally, except that:

- Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and coinsurance factors thereto need not be the same as applicable to physical illness generally.

- Outpatient benefits may be limited to $1,000 for consultations with a licensed mental health professional. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.

- Partial hospitalization benefits must be provided under the direction of a licensed physician. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs must also be qualified providers under this section. In any benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid for all such services must not exceed the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond these limits, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Although the federal “Mental Health Parity Act of 1996" applies to health insurance policies issued in Florida, the Department of Insurance has no enforcement authority over this law. In addition, the federal law may be in conflict with several of the provisions in state law. In the event of a conflict, federal law prevails.

Medical Savings Accounts (MSA)

As a part of HIPAA, Congress authorized a four year MSA demonstration project, which runs through January 1, 2001. During the four year period, the total number of tax exempt MSAs is limited to 750,000, excluding previously uninsured persons.

Here is how an MSA works. An individual or employer makes monthly tax-free deposits into a policyholder's MSA, established through a bank or insurance company. The account holder must also have a high-deductible, or catastrophic, health insurance policy that kicks in after the deductible is reached. There are no restrictions on which party covers the cost of the high deductible plan, and employers typically pay 75 percent of the premium.

The allowable deductible ranges from $1,500 to $2,250 for individual coverage, with a maximum of $3,000 in out-of-pocket expenses, and $3,000 to $4,500 - with an out-of-pocket maximum of $5,500 - for families. No more than 65 percent of the deductible for single coverage, and 75 percent of the family deductible, can be deposited in an MSA annually. Although the feds did not establish minimum funding levels, the bank or insurance company that issues the MSA may set its own funding floor.

Money is withdrawn from the MSA - typically by check or debit card but some plans require individuals to file written claims - to pay for qualified medical expenses, which include vision and dental care, prescription drugs, psychotherapy and physical therapy as well as basic doctor and hospital bills.

At the end of the year, leftover funds can be rolled over into the following year's MSA deposit or left to accumulate a tax-free nest egg. Remaining MSA funds can also be used, without tax penalty, to pay premiums for long-term care insurance, COBRA coverage and health insurance for an individual receiving unemployment compensation. Any funds spent on non-medical, or unqualified expenses are subject to income tax and a 15 percent withdrawal penalty, with the exception of policyholders over age 65, who can make penalty-free withdrawals for non-medical expenses.

Protection from Creditors

Article X, section 4 of the Florida Constitution allows a debtor to exempt a homestead of unlimited value from the claims of creditors as long as it is used as a residence. Specifically, section 4 provides that a person may exempt up to 160 acres if the property is located outside a municipality or up to 1/2 acre if the property is located within a municipality. Courts have held that the purpose of the article X, section 4 exemption is to preserve for an unfortunate citizen and his family certain things necessary to earn a livelihood. Vandiver v. Vincient, 130 So.2d 704 (Fla. 2d DCA 1962). See also In re Owen, 961 F.2d 170 (under the Florida Constitution, homestead property is exempt from forced sale and is insulated from judgment, decree or execution lien).

In addition to the protection from creditors for homestead contained in the Constitution, s. 222.22, F.S., provides that moneys paid into or out of a Florida Prepaid Postsecondary Education Expense trust fund, established pursuant to s. 240.551, F.S., are not liable to attachment, garnishment, or legal process in favor of any creditor of the purchaser or beneficiary of the advance payment contract, so long as the contract has not been terminated.

HMO Outpatient Holding Beds

In a 1987 rewrite of chapter 641, F.S., relating to HMOs, the Legislature exempted from regulation under chapter 395, F.S., (the hospital licensing chapter) up to 10 outpatient holding beds within an HMO for short-term and hospice-type patients (see s. 21 of ch. 87-236, L.O.F., codified as s. 641.495(10), F.S.). The exemption required that the HMO be accredited. This exemption was amended in 1991 so that it applied only to such beds in place on or before January 1, 1991. Only one HMO ever had these type of beds and the limitation imposed in 1991 prevented the acquisition of such beds by any other HMO.

In 1996, s. 641.495 was amended by s. 32, ch. 96-199, L.O.F., which purported to amend s. 641.495 in its entirety, but the amendment did not publish the text of existing subsection (10), which contains the HMO exemption for outpatient beds. This fact is foot noted in the Florida Statutes.

HMO Surplus Requirements

Current Florida law (s. 641.225, F.S.,) requires an HMO to maintain a minimum surplus of $.5 million or 10 percent of total liabilities, whichever is greater. In addition, each HMO must deposit with the Department of Insurance, in cash or securities, an amount which is the greater of twice the HMO's reasonably estimated average monthly uncovered expenditures or $100,000. Recently, two HMOs have failed financially and have had to be rehabilitated by the Department of Insurance. These two financial failures have caused the department to question the adequacy of current minimum surplus and solvency requirements.

Contraceptive Coverage

While most employment-related insurance policies in the United States cover prescription drugs, a vast majority excludes coverage for prescription contraceptive drugs or devices. Several states require contraceptives to be offered in insurance policies, but only Virginia has passed legislation requiring policies to cover contraceptives. Several states, including California, Alaska, Connecticut, Utah and Georgia are considering legislation calling for "Equity in Prescription Insurance and Contraceptive Coverage", and similar legislation is being considered by Congress.

Close to 50% of all pregnancies in the United States are unintended, and half of all unintended pregnancies end in abortion. A 1994 Florida study showed that 45.8% of pregnancies in Florida were unintended, and 24% of those unintended pregnancies ended in induced abortion. Proponents of legislation calling for contraceptive coverage argue that contraceptives have been proven to prevent unintended pregnancies and, as a result, reduce the number of abortions. California research shows that access to contraceptives reduces the probability of having an abortion by 85%. Proponents also argue that a providing a policy holder with a monthly supply of birth-control pills will cost insurance companies much less than the cost for prenatal care and delivery charges resulting from a woman's unexpected pregnancy.

Opponents of contraceptive coverage include insurance companies and religious groups. Insurance companies argue that mandated contraceptive coverage would increase the cost of premiums and may force small-business owners into dropping their insurance plans completely. Religious groups, particularly Catholic organizations, are concerned with the moral implications and conscience conflicts that may result from such legislation. Religious opponents argue that employers should not be forced to offer and pay for coverage of birth control when it violates their religious teachings and deeply held moral beliefs.

Contraceptives are also used for purposes beyond birth-control purposes. Doctors prescribe birth-control pills for several conditions, including prevention of ovarian cancer, management of painful or heavy menstrual periods, symptoms of menopause, and endometriosis, a painful disease in which the uterine lining grows outside the uterus.

A 1994 study by the Women's Research and Education Institute in Washington found that women of reproductive age pay 68 percent more than men in out-of-pocket expenses for health care, and much of this difference in expenditures is due to contraceptive supplies and services. A monthly supply of birth-control pills costs between $20 and $30. Insurance companies are more likely to cover abortion services than contraceptives. A vast majority of insurance plans cover sterilization and most insurers pay for vasectomies.

An insurance industry study has found that the cost of extending the prescription contraceptive benefit would be $16 per employee each year. According to the American Journal of Public Health, the managed care cost for one year of a contraceptive pill is $422 while the cost of prenatal care and delivery for each unintended pregnancy carried to term in $5,512.

Professional Liability Claims and Actions

Section 627.912, F.S., requires each self-insurer authorized under s. 627.357, F.S., and each insurer or joint underwriting association providing professional liability insurance to a medical or osteopathic physician, a podiatrist, a dentist, a hospital, a crisis stabilization center, an HMO, an abortion clinic, an ambulatory surgical center, or to a member of the Florida Bar to report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in: a final judgment in any amount; a settlement in any amount; or a final disposition not resulting in payment on behalf of the insured. Reports must be filed with the department and, if the insured party is a physician, podiatrist, or dentist, with the Agency for Health Care Administration, no later than 30 days following the occurrence of any event listed in the foregoing. The Agency for Health Care Administration is required to review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action. In addition, the agency is required to publish an annual report which includes statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the agency or the appropriate regulatory board.

Most health care providers are included in this requirement to report but there are exceptions. On example are health care providers who obtain liability insurance through a fund established pursuant to s. 240.213, F.S. in the Board of Regents. Providers participating in this fund include: the University of Florida, J. Hillis Miller Health Center pursuant to s. 240.513(4)(d), F.S.; the H. Lee Moffitt Cancer Center and Research Institute pursuant to s. 240.512(3), F.S.; and the University Hospital of Jacksonville and Faculty Clinic, pursuant to s. 240.5135, F.S.

B. EFFECT OF PROPOSED CHANGES:

The Florida Department of Insurance will have the authority to enforce the provisions of the federal "Mental Health Parity Act", which will be codified into the Florida Insurance Code.

Women with an insurance policy or HMO contract that covers prescription drugs will have access to FDA approved prescription contraceptives.

Requirements in state law relating to renewal of conversion policies and Medicare supplement policies will be consistent with federal requirements.

The provisions of Florida's Long-Term Care Insurance Act which apply to limited benefit policies will be clarified. Limited benefit policies will be required to include a disclosure statement for prospective policyholders which indicates that the limited benefit policy either meets federal qualifications for tax exemption or does not, and the definition of "preexisting condition" for long-term care policies in the Florida Insurance Code will be consistent with the federal definition contained in HIPAA.

Moneys paid into or out of a Medical Savings Account will not be liable to attachment, garnishment, or legal process on behalf of a person establishing the MSA or the beneficiary of the MSA. Also, the one HMO which, on or before January 1, 1991, had fewer than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members will continue to be exempt from regulation under part I of chapter 395, F.S., so long as the HMO meets specified accreditation requirements.

HMOs will be less likely to become insolvent due to enhanced solvency protection standards.

The Board of Regents' self-insurance program will be required to report to the Department of Insurance claims for actions for damages for personal injures related to care provided by certain health care providers participating in the fund, including medical and osteopathic physicians, podiatrists, and dentists.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, the bill gives the Department of Insurance additional rule making authority and enforcement authority.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, insurance companies and HMOs will be required to provide additional benefits, and HMOs will be required to meet enhanced solvency protection standards. The Board of Regents will be required to report data to the Department of Insurance on professional liability claims.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

N/A

d. Does the bill reduce total fees, both rates and revenues?

N/A

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Insurance companies pay for regulatory costs through licensing fees. These costs are passed on to consumers through premium increases. Therefore, consumers who benefit from this legislation pay the cost.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 222.22, 627.64061, 627.6515, 627.6571, 627.65741, 627.6699, 627.6675, 627.6685, 627.674, 627.6741, 627.912, 627.9403, 627.9404, 627.9407, 627.94073, 641.225, 641.285, 641.31, 641.31074, 641.3922, and 641.495 F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 222.22, F.S., relating to exemption of moneys from legal process, to specify that moneys paid into or out of a Medical Savings Account by or on behalf of a person depositing money into an MSA are not liable to attachment, garnishment, or legal process in favor of any creditor.

Section 2. Provides that section 3, ss. 627.64061, 627.65741, and 641.31(4), F.S., and the amendments to s. 627.6515, and s. 627.6699, F.S., providing for the application of s. 627.65741, F.S., may be cited as the "Equity in Prescription Insurance and Contraceptive Coverage Act of 1998".

Section 3. Provides the legislative findings and intent of the "Equity in Prescription Insurance and Contraceptive Act of 1998".

Section 4 . Creates s. 627.64061, F.S., relating to coverage for prescription contraceptives, to provide that any health insurance policy that provides coverage for outpatient prescription drugs shall cover prescription oral contraceptives. No insurer or policy holder is required to provide or purchase coverage for oral contraceptives if the insurer or certificate holder objects on religious or moral grounds. In addition, the provisions of the section do not apply to any prescription medication which is abortifacient in nature.

Section 5. Amends s. 627.6515, F.S., relating to out-of-state group health insurance policies, to require that these policies comply with the provisions of s. 627.65741, F.S.

Section 6. Amends s. 627.6571, F.S., relating to guaranteed renewability of converge, to make a technical correction.

Section 7. Creates s. 627.65741, F.S., relating to coverage for prescription contraceptives, to provide that any group, franchise accident, or health insurance policy that provides coverage for outpatient prescription drugs shall cover prescription oral contraceptives. No insurer or policy holder is required to provide or purchase coverage for oral contraceptives if the insurer or certificate holder objects on religious or moral grounds. In addition, the provisions of the section do not apply to any prescription medication which is abortifacient in nature.

Section 8. Amends s. 627.6675(7)(b), F.S., relating to eligibility for conversion health insurance policies, to amend language related to renewal of conversion policies. Current law allows for non-renewal based on fraud or material misrepresentation by the policyholder. This bill substitutes the word "intentional" for "material". This bill also deletes the provision that allows an insurer to non-renew a conversion policy due to the

policyholder becoming eligible for Medicare or any other state or federal law providing for benefits similar to those provided under the converted policy.

Section 9. Creates s. 627.6685, F.S., relating to mental health coverage, with the following subsections:

Subsection (1) - Creates definitions for the section.

Subsection (2) - Specifies limitations on plan benefits. If a group health plan contains no aggregate lifetime limit or annual limit on medical benefits, the plan may not impose an aggregate lifetime limit or annual limit on mental health benefits. If a plan does include an aggregate lifetime limit or annual limit on medical benefits, the plan must either not distinguish between medical benefits and mental health benefits in the application of the aggregate lifetime limit or annual limit, or not include any aggregate lifetime limit or annual limit on mental health benefits which is less than that limit. In the case of a plan not described in the foregoing, the department is required to adopt rules to deal with situations where policies include limits on individual components of the policy, to provide parity between medical benefits and mental health benefits. Nothing in this section requires a plan to provide any mental health benefits, or as affecting the terms and conditions of a mental health benefit if such benefit is provided, such as limiting the number of visits or days of coverage and requirements relating to medical necessity, the amount, duration, or scope of mental health benefits covered, except with respect to parity for aggregate lifetime limits and annual limits.

Subsection (3) - The provisions of this section are not applicable to any small group policy issued under the “Health Care Access Act” (s. 627.6699, F.S.); and the section does not apply to any plan where it will result in an increase in the cost of the plan of at least one percent.

Subsection (4) - Specifies that the provisions of this section apply separately to each option for any plan which offers two or more benefit package options.

Subsection (5) - Specifies that the section does not apply after September 30, 2001.

Subsection (6) - Provides that the provisions of this section prevail in the event there is a conflict between this section and s. 627.668, F.S., which relates to optional coverage for mental and nervous disorders.

Section 10. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to require that these policies comply with the provisions of s. 627.65741, F.S.

Section 11. Amends s. 641.31, F.S., relating to health maintenance contracts, to provide that health maintenance contracts that provides coverage for outpatient prescription drugs shall cover prescription oral contraceptives. No insurer or policy holder is required to provide or purchase coverage for oral contraceptives if the insurer or certificate holder objects on religious or moral grounds. In addition, the provisions of the section do not apply to any prescription medication which is abortifacient in nature.

Section 12. Amends s. 627.674, F.S., relating to minimum standards for Medicare supplement policies, to requires that rules adopted by the department must be no less comprehensive or beneficial to insureds than federal law.

Section 13. Amends s. 627.6741, F.S., relating to issuance, cancellation, and renewal of Medicare supplement policies, to revise standards for the issuance of Medicare supplement policies. Current Florida Law requires insurers to guaranty the issuance of coverage to any individual during the first 6 months after they reach age 65 and enroll in Part B, and to any individual who is 65 or older during the 2 month period following termination of coverage under a group plan. This amendment provides that if any such individual has at least 6 months of prior creditable coverage, the Medicare supplement policy may not exclude benefits based on a pre-existing condition. Credit must be given towards a pre-existing condition exclusion for time covered under a previous Medicare supplement policy or a group policy.

Section 14. Amends s. 627.912, F.S., relating to professional liability claims and actions; reports by insurers, to require the self-insurance program established under s. 240.213, F.S., (the Board of Regents of the State University System) to report to DOI any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services. The requirement applies to medical and osteopathic physicians, podiatrists, and dentists.

Section 15. Amends s. 627.9403, F.S., relating to scope, to clarify that a limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care specified by department rule must meet all requirements of Part XVII of ch. 627, F.S., relating to long-term care insurance policies, except specified provisions which are not applicable.

Section 16. Amends s. 627.9404, F.S., relating to definitions, to define “limited benefit policy”.

Section 17. Amends s. 627.9407, F.S., relating to disclosure, advertising and performance standards, to revise the definition of “preexisting condition” in order to conform it to the federal definition; and to specify that a limited benefit policy which is qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement to that affect. Limited benefit policies which are not federally qualified must also disclose that to the prospective policyholder.

Section 18. Amends s. 627.94073, F.S., relating to notice of cancellation and grace periods, to make a technical change in subsection (2) to clarify the application of the subsection to limited benefit insurance policies.

Section 19. Amends s. 641.225, F.S., relating to HMO surplus requirements, to increase minimum surplus requirements from $.5 million to $1.5 million, or 10 percent of total liabilities, or 2 percent of annualized premium, which ever is greater. These increases in minimum surplus requirements will be phased in over a three year period.

Section 20. Amends s. 641.285, F.S., relating to HMO insolvency protection, to each HMO to deposit with the Department of Insurance $300,000 (and from $100,000 up to $2 million based on financial conditions).

Section 21. Amends s. 641.31074(2)(d) and (3) (a) and (b), F.S., relating to guaranteed renewability of coverage, to make technical corrections.

Section 22. Amends s. 641.3922(7)(a), F.S., relating to eligibility for conversion health maintenance organization policies, to amend language related to renewal of conversion policies. Current law allows for non-renewal based on fraud or material misrepresentation by the policyholder. This bill substitutes the word “intentional” for “material”. This bill also deletes the provision that allows an insurer to non-renew a conversion policy due to the policyholder becoming eligible for Medicare or any other state of federal law providing for benefits similar to those provided under the converted policy.

Section 23. Amends s. 641.495(11), F.S., relating to requirements for issuance and maintenance of a certificate, to insert a provision which exempts from licensure under chapter 395, F.S., certain beds of a health maintenance organization. The provision was inadvertently deleted by the Legislature in 1996.

Section 25. Provides an effective date of July 1, 1998.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

According to Milliman and Roberts, Actuaries and Consultants, the provisions of the Federal Mental Parity Act of 1996 will result in increased costs to the State Self-Insured plan of approximately $3 million in fiscal year 1998-99, or slightly less than one percent of total paid claims.

The fiscal impact of requiring coverage for FDA approved oral contraceptives is indeterminate.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

$3 million in fiscal year 1998-99.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

Indeterminate.

2. Recurring Effects:

Indeterminate.

3. Long Run Effects Other Than Normal Growth:

Indeterminate.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

HMOs will experienced increased costs associated with meeting the higher surplus and solvency requirements. Insurance and HMO premiums may increase to pay for mental health benefits and prescription, oral contraceptives.

2. Direct Private Sector Benefits:

Florida consumers will have recourse through the Florida Department of Insurance for violations of the federal “Mental Health Parity Act of 1996". Moneys paid into or taken out of an MSA will not be available to creditors of the entity which established the MSA or the beneficiary of the MSA. Women who have private health insurance or HMO coverage may experience lower costs for prescription, oral contraceptives. The financial soundness of HMOs will be enhanced. Consumers and regulatory agencies will have access to information regarding any claim or action for damages for personal injuries claimed to have been caused by negligence in the performance of professional services by a physician, podiatrist, or dentist who obtains professional liability insurance through the Board of Regents.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

It is estimated in the literature that adding a prescription oral contraceptive benefit to an insurance policy increases the annual price by from $16 to $24.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill may require counties and municipalities to spend funds or to take an action requiring the expenditure of funds related to the provision of employee health benefits. However, two constitutional exemptions apply: all similarly situated persons are required to comply; and the mental health parity component oft this bill is required to comply with a federal requirement.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

Portions of this bill were prepared at the request of the Department of Insurance.

Reporting requirements on professional liability-related claims for the Board of Regents self-insured fund do not include reporting by health care facilities, including hospitals. This is a departure from the reporting requirements contained elsewhere in s. 627.912, F.S., which apply to health care facilities as well as physicians, dentists and podiatrists.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

This bill was discussed at the January 5, 1998 meeting of the Health Care Services Committee which adopted 4 amendments as follows:

Amendment 1 specifies that funds in a medical savings account are liable to attachment, garnishment, or legal process.

Amendment 2 reinserts in statute a provision which was inadvertently repealed to permit HMOs to have up to 10 outpatient holding beds.

Amendments 3 and 4 were technical in nature.

On March 3, 1998, the Health Care Services Committee adopted an amendment relating to Medicare Supplement policies to make changes necessary to conform to federal law. Specifically, the amendment requires that rules adopted by the department must be no less comprehensive or beneficial to insureds than federal law. Further, the amendment revises standards for the issuance of Medicare supplement policies. Current Florida Law requires insurers to guaranty the issuance of coverage to any individual during the first 6 months after they reach age 65 and who enrolls in Part B, and to any individual who is 65 or older during

the 2 month period following termination of coverage under a group plan. This amendment provides that if any such individual has at least 6 months of prior creditable coverage, the Medicare supplement policy may not exclude benefits based on a pre-existing condition. Credit must be given towards a pre-existing condition exclusion for time covered under a previous Medicare supplement policy or a group policy.

On March 9, 1998, the Health Care Services Committee adopted an amendment relating to coverage for contraceptives. The amendment creates the Equity in Contraceptive Coverage Act of 1998, which requires certain health insurance policies and health maintenance contracts to provide coverage for prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by an authorized practitioner. This section does not require an insurer to provide coverage for prescription oral contraceptives if the insurer or policy holder objects on religious or moral grounds, nor does this section apply to any prescription medications which are abortifacient in nature.

On March 11, 1998, the Committee on Health Care Services adopted two amendments to the bill. The first amendment revises ch. 641, F.S., relating to HMO surplus and solvency requirements, to increase minimum surplus requirements from $.5 million to $1.5 million, to require a deposit of cash or securities with the department of $300,000 (or up to $2 million based on financial conditions), and to require HMOs to file a report on internal control in conjunction with its CPA report. The second amendment exempts policies which provide for expanded coverage, written in conjunction with comprehensive medical policies, from the requirements of the small group law.

On March 18, 1998, the Committee on Health Care Services adopted 4 additional amendments. The first two were technical in nature. The third removed from the bill the enhanced reporting requirements for HMOs amended in the previous week. And the fourth amendment requires reporting to DOI of any claim or action for damages for personal injuries claimed to have been caused by negligence in the performance of professional services by a physician, podiatrist, or dentist who obtains professional liability insurance through the Board of Regents.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen