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DATE: March 27, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1571

RELATING TO: Small Employer Health Alliances

SPONSOR(S): Representatives Farkas and Goodlette

TIED BILL(S):

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

(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(4)
(5)

I. SUMMARY:

HB 1571 addresses issues relating to insurance coverage available to small employers. The bill:

- Repeals existing statutory provisions relating to community health purchasing alliances (CHPAs);
- Authorizes a health insurance carrier to issue a group policy to a small employer health alliance organized as a not-for-profit entity, for the purpose of obtaining insurance;
- Enables such policies to insure a small employer, including sole proprietors and self-employed individuals and the spouses and dependents of such employees; and
- Permits small employer policy rates to:
  - Reflect premium credits attributable to documentable administrative savings resulting from such pooling of the small employers, and
  - Be adjusted under specified circumstances relating to periods of renewal related to coverage transfer.

The bill's effective date is October 1, 2000.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Community Health Purchasing Alliances

In 1993, the Legislature created Community Health Purchasing Alliances, or CHPAs (commonly referred to as “chippas”), via ch. 93-129, L.O.F., codified as ss. 408.70-408.706, F.S. These state-chartered, nonprofit private organizations were designed to pool purchasers of health care insurance together as organizations that could foster health coverage purchasing to lower prices and enable purchasers to make informed choices regarding health plans. The goal of CHPAs was to make health insurance plans available to small employers, as that term is defined in s. 627.6699, F.S., that have 1 to 50 employees, including sole proprietors and self-employed individuals.

The Agency for Health Care Administration (AHCA) is responsible for implementation and oversight of the statewide system of CHPAs, including technical and legal assistance, liaison functions, and designation of accountable health partnerships (AHPs). In order for an insurance product to be offered through CHPAs, the product must qualify as an AHP, which must be formed by an insurer or health maintenance organization (HMO) authorized by the Department of Insurance. The CHPAs act as clearinghouses for health plans that qualify as AHPs. The AHPs are selected via a request-for-proposals process. CPHAs offer several benefit plans. Within these plans, an individual can select different types of coverage, such as HMOs and preferred provider organizations. All CHPA plans are sold through insurance agents.

The 1993 enabling legislation created 11 CHPAs, one for each of AHCA’s health service planning districts. There are now seven CHPAs, due to mergers of certain CHPAs from neighboring regions. Each CHPA operates under the direction of an appointed 17-member board of directors. The original law that provided for appointment of board members by designated public officials was repealed due to a “sunset” provision and failure of the Legislature to reenact the provision. Thus, the boards, as nonprofit associations, provide for appointment of board members in their respective articles of incorporation and bylaws continue to provide for appointment of members in the manner that was statutorily directed. The boards appoint executive directors who serve as CHPAs’ chief operating officers. Each CHPA also employs from one to three full-time staff, and all but one of the CHPAs contract with a third-party administrator.

As of February, 2000, approximately 35,000 persons, including employees and their dependents, were insured through CHPAs, representing about 13,000 small employer groups. This represents a decrease from the 94,090 persons who were covered through CHPAs in December 1998. Only seven carriers remain as active AHPs in the CHPA market, and some of these are active in only certain districts. Fifteen carriers have discontinued their participation in AHPs in some or all of the CHPA districts.

The Office of Program Policy Analysis and Government Accountability (OPPAGA) has issued reports on the activities and effectiveness of CHPAs. The most recent OPPAGA report, "The Follow-Up Report on the Status of Community Health Purchasing Alliances in Florida," Report No. 98-14, October 1998, stated that the CHPAs continue to have a small impact in reducing the number of uninsured Floridians. Limitations of the CHPAs as cited in the report included:

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

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

The OPPAGA report recommended that the Legislature consider the following policy options:

- Allow CHPAs to negotiate with competing health plans and select those that offer the most competitive products and prices;

- Reduce AHCA's responsibilities to minimal oversight and coordination among CHPAs; and

- Enable CHPAs to appoint their agents.

It should also be noted that s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, is physically located in the statutes in the middle of various CHPA provisions. As a result, the definitions used in this portion of ch. 408, F.S., are applicable to this program and the CHPAs.

Related Insurance Provisions

Part VII, ch. 627, F.S., establishes requirements for each of the types of groups to whom a health insurer may issue a group policy. A health insurer may not issue a policy to a group to cover members of that group unless it meets the requirements of one of the statutorily authorized groups. Under the provisions of s. 627.654, F.S., a group policy may be issued to an association, including a labor union, which has a constitution and bylaws, at least 25 members, and has been organized and maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance. A policy issued to an association must allow all individual members of the association, or any class or classes of the association, to be eligible and acceptable to the insurer at the time of the issuance of the policy.

Under the provisions of s. 627.6571, F.S., group health insurance policies must be guaranteed renewable, with certain exceptions. One exception is that if health insurance coverage is made available only through one or more bona fide associations, which in this context are defined as including a requirement that the association be formed for purposes other than obtaining insurance.

Section 627.6699, F.S., the Employee Health Care Access Act, applies to all health insurance plans that are sold to a small employer, defined as one with 1 to 50 employees, including sole proprietors and self-employed individuals. This act requires guaranteed issuance of coverage to all small employers, regardless of health condition. It also requires that rates be based on a modified community rating methodology, which prohibits insurers from basing rates on the health conditions or claims experience of any person insured under a small group policy. Rates for a small employer policy may be based only on the following factors: age, gender, geographic locations, tobacco usage, and family composition (size).

C. EFFECT OF PROPOSED CHANGES:

The bill: repeals existing statutory provisions relating to community health purchasing alliances; authorizes a health insurance carrier to issue a group policy to a small employer health alliance organized as a not-for-profit entity, for the purpose of obtaining insurance; such policies may insure a small employer, including sole proprietors and self-employed individuals and the spouses and dependents of such employees; and permits small employer policies to: reflect premium credits attributable to administrative savings attributable to such pooling and adjust rates under specified circumstances.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends subsection (1) of s. 408.7056, F.S., relating to definitions that are specifically applicable to the Statewide Provider and Subscriber Assistance Program, to add definitions of the following terms: “agency,” “department,” “grievance procedure,” “health care provider,” and “health plan.” [NOTE: These definitions are currently contained in s. 408.701, F.S., as definitions applicable to ss. 408.70-408.706, F.S., relating to community health purchasing alliances, accountable health partnerships, and the Statewide Provider and Subscriber Assistance Program, but the provisions of s. 408.701, F.S., are repealed as part of section 11 of the bill.]

Section 2. Amends s. 627.654, F.S., relating to basis upon which insurance can be offered through labor union and association groups, to expand the applicability of this section to include small employer health alliances. In so doing, the following specific revisions are incorporated:

The title of the section is redesignated to include small employer health alliance groups.

Existing subsection (1) is redesignated as paragraph (a) of subsection (1), and a new paragraph (b) is added to the subsection to authorize a new type of association policy to be issued to a small employer health alliance. Such an alliance must be organized as a not-for-profit corporation under ch. 617, F.S. (In contrast to existing language in what is redesignated as paragraph (a), this language is silent as to whether such an alliance may be formed solely for insurance coverage purposes, which implies that this is an acceptable reason to form an alliance.) The alliance must establish conditions of participation in the alliance by a small employer, including but not limited to: assurance that the alliance is not formed for the purpose of securing health benefit coverage, including requirements for sole proprietors and self-employed individuals and based on a specified requirement for the time that the sole proprietor or self-employed individual has been in business, required filings to verify employment status, and other requirements to ensure that the individual is working; and assurance that the

employees of a small employer have not been added for the purpose of securing health benefit coverage.

Subsection (2) is modified to specify that for alliances, just like for associations now, a policy issued must allow all individual members, or any class, to be eligible and acceptable to the insurer at the time of issuance of the policy.

Subsection (3) is amended to specify that, like associations, alliances may insure the spouse and dependent children of an employee of a small employer in a small employer health alliance without the employee eligible for coverage in the alliance being covered.

Section 3. Amends s. 627.6571, F.S., relating to guaranteed renewability of coverage, to: provide an exception to the guaranteed renewability requirements specific to a small employer whose membership in the alliance ceases; and incorporate coverage modifications for alliances consistent with current provisions applicable to bona fide associations.

Section 4. Amends s. 627.6699, F.S., relating to the Employee Health Care Access act, to incorporate the following revisions:

Subsection (5), relating to availability of coverage, is amended to incorporate a conforming revision deleting a cross-reference to s. 408.706, F.S., which is repealed by section 11 of the bill.

Subsection (6), relating to restrictions relating to premium rates, is amended to: provide an exception to the prohibition against small employer carriers modifying the rates for small employers for 12 months from the initial date of issuance or date of renewal to allow an insurer to modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers, provided the insurer discloses to the employer the date of first renewal and the fact that the premium may increase on that date. This subsection is further amended to provide as an additional factor that may be used in establishing rates similar to an existing rule of the Department of Insurance that allows rates for a policy issued to a group association or an alliance that reflect a premium credit for expense savings attributable to administrative activities being performed by the association or alliance, if these savings are specifically documented in the carrier's rate filing and approved by the department. A provision which allows small group carriers who participate in CHPAs to apply a different community rate for CHPA business is deleted, as a conforming revision.

Subsection (12), relating to standard, basic, and limited health benefit plans, is amended to incorporate conforming revisions.

Sections 5-10. Amends the following sections of statute, relating to the indicated topic, to incorporate conforming revisions that either delete reference to an accountable health partnership or managed care as those terms are defined in s. 408.701, F.S.:

s. 240.2995	University health support organizations
s. 240.2996	University health support organizations; confidentiality of information
s. 240.512	H. Lee Moffitt Cancer Center and Research Institute
s. 381.0406	Rural health networks
s. 395.3035	Confidentiality of hospital records and meetings

s. 627.4301 Genetic information for insurance purposes

Section 11. Repeals the following sections of statute relating to the indicated topics:

s. 408.70(3)	Legislative intent specific to community health purchasing alliances
s. 408.701	Community health purchasing; definitions
s. 408.702	Community health purchasing alliance; establishment
s. 408.703	Small employer members of community health purchasing alliances; eligibility requirements
s. 408.704	Agency duties and responsibilities related to community health purchasing alliances
s. 408.7041	Antitrust protection
s. 408.7042	Purchasing health care for state employees and Medicaid recipients through community health purchasing alliances
s. 408.7045	Community health purchasing alliance marketing requirements
s. 408.7055	Practitioner advisory groups
s. 408.706	Community health purchasing alliances; accountable health partnerships

Section 12. Provides for an October 1, 2000, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The Agency for Health Care Administration currently has 10 full time equivalent positions associated with the CHPA program. All of these positions are deleted in the Governor's recommended budget and in both the current House and Senate appropriations proposals, with a total reduction of $634,709 in salaries and expenses. For this reason, this bill does not have an associated fiscal impact savings.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Participation by insurers and small employers in CHPAs has been declining for some time, making it increasingly unlikely that all existing CHPAs will continue to be viable entities.

Small employers would still be able to obtain coverage on a guaranteed-issue, modified community-rated basis apart from the CHPAs, but most employers are experiencing significant rate increases. The bill is intended to more effectively pool groups of individuals employed by small employers and their dependents, into larger groups in order to facilitate a program of affordable group health insurance coverage.

The bill does not provide any specific legal advantage to the former CHPAs that could be issued an alliance group policy, as compared to other alliance or association groups, such as a local Chamber of Commerce associations.

D. FISCAL COMMENTS:

N/A

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

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:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

On March 21, 2000, Senator King, sponsor of SB 2086, and Representative Farkas, sponsor of this bill, conducted a workshop on these bills. Interested parties were invited to express any concerns with the bills and to offer any suggestions for improvements. Concerns raised included those relating to definitional issues relating to “small groups,” the applicability of the small group rating law, intent with regard to ”administrative” issues, role of alliances, impact of the bill on competition in the small group market, and ability of insurance carriers to return to Florida for purposes of alliance coverage.

When the companion measure, SB 2086, was heard in the Senate Banking and Insurance Committee on March 27, 2000, a series of amendments were adopted to reflect the compromises that the sponsors have reached with interested parties. That bill, as amended, was approved as a committee substitute.

The sponsor of HB 1571 has indicated his intent to offer a strike-everything amendment to conform the bill to CS/SB 2086.

Though not directly related, the provisions of this bill are somewhat linked to the provisions of HB 687, approved by the Committee on Health Care Services on March 16, 2000. While this bill would only allow administrative savings resulting from activities performed by the alliance, HB 687 allows small group rates to reflect an adjustment of up to plus or minus 15 percent based on health status or claims experience.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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