SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2152

SPONSOR: Governmental Oversight and Productivity Committee and Senator Latvala

SUBJECT: Mandated Health Insurance Benefits and Providers Estimating Conference

DATE: April 25, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rhea	Wilson	GO	Favorable/CS
2.			RC	
3.				
4.				
5.				

I. Summary:

The committee substitute provides for the Mandated Health Insurance Benefits and Providers Estimating Conference and establishes duties of that conference. When a legislative measure containing a mandated health insurance benefit or provider is proposed, the standing committee of the Legislature which has jurisdiction over the proposal is required to request the conference to prepare and forward to the Governor and the Legislature a study that provides for each measure a cost-benefit analysis. The standing committee may not consider such a proposed legislative measure until 12 months after it has requested the conference's report on the measure.

This committee substitute amends the following sections of the Florida Statutes: 216.136 and 624.215.

II. Present Situation:

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as *mandated health benefits*. Mandated health benefits are estimated to affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who either are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers also are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) generally preempts state regulation of these plans.[1]

In 1987, the Legislature called for a systematic review of current and proposed mandated benefits. At that point, the Legislature had approved 16 mandated benefits. Since that time, the Legislature has approved an additional 35 mandated benefits. With a total of 51 mandated health benefits applicable either to private insurer or HMO health plans, Florida now has one of the nation's most

[1] 29 U.S.C. s. 1001, et. seq.

extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits, submission of an impact analysis for any proposed mandated benefit by proponents prior to consideration, does not appear to have been used frequently.[2]

In 1998, nearly a quarter of non-elderly Floridians were uninsured. According to the 1998 Health Confidence Survey sponsored by the Employee Benefit Research Institute, 48 percent of the uninsured nationwide cite cost as the primary reason for being uninsured. Costs would have to be "cut in half " to entice one-third of these respondents back into the marketplace, according to at least one study.

It is not always apparent in statute which health plans are subject to which state-mandated health benefits. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs. As a result, estimates for the number of mandated health benefits in Florida vary, ranging from 44 to 51. Of these, 40 apply to either private individual or group policies provided by insurers. Individual policies are subject to 34 and group policies to 39. Health maintenance organizations must comply with 39 mandated benefits.[3]

An estimated 33 percent of all Floridians are covered under health plans subject to mandated health benefits. These Floridians are covered under a private insurer or HMO plan, other than a basic or standard small employer group plan. The other 67 percent are unaffected by mandated health benefits because they either are uninsured or covered under plans not subject to these mandates. These include Medicare or Medicaid plans, and self-funded ERISA plans provided by certain employers. Among insured Floridians, 40 percent are in plans subject to mandated health benefits.

Health Plans	Insured Floridians	% of all Floridians	Mandates Applicable
Insurer/HMO	40%	33%	Yes
Self-Funded Employer	26%	21%	No
Medicare	22%	18%	No
Medicaid	12%	10%	No
No health plan/uninsured	N/A	17%	N/A

In 1992, in the Florida Employee Health Care Access Act,[4] the Legislature authorized insurers and HMOs to offer "basic" and "standard" small employer group plans and exempted these 2 plan types from mandated coverages not expressly made applicable to these plans in law. For the period ending December 31, 1998, these 2 plan types accounted for only $139 million in earned premium or just over 8 percent of the more than $1.7 billion in premium earned for all small employer group plans, according to figures provided by the Department of Insurance. According

[2]Staff of the House Committee on Insurance could confirm only 4 instances since 1987 in which the required study was completed for a mandated benefit.

[3]BlueCross BlueShield Association, State Legislative Health Care and Insurance Issues: 1998 Survey of Plans.

[4]Section 627.6699, F.S.

to the Department of Insurance small employer enrollment report for the period ending June 30, 1999, the number of lives covered under a basic or standard plan was 276,000 of over 1.7 million individuals covered under a small employer group plan.

Although mandated health benefits apply only to private insurer and HMO health plans, there are instances when Floridians receive comparable benefits either under an exempt self-funded ERISA plan, or through Medicaid or Medicare.[5] However, these plans are either paid for by the general public, as in the case of Medicaid and Medicare, or funded voluntarily by those with the freedom to design a plan with benefits they are willing to purchase, such as an employer with a self-funded plan. In contrast, insurer and HMO plans are paid for by those securing the coverage, regardless of whether or not they want to purchase all of the mandated benefits.

The Legislature has recognized in legislative intent that "most mandates contribute to the increasing cost of health insurance premiums." Insurers and HMOs contend mandated benefits increase costs by: 1) increasing utilization of health care services; 2) giving providers of certain benefits pricing leverage; and 3) by requiring them to include additional benefits.

By stating that "most" mandates increase costs, that same legislative intent recognizes that some mandates may not increase premium costs. These could be of at least two types: one, a preventative care mandate, such as mammogram screening or well-child care; and two, a mandated treatment or provider substituting for a more expensive alternative. Certain mandated benefits may not necessarily reduce premium costs but may reduce the costs borne by the general public.

Calculating the cost of mandated health benefits can be difficult. Cost determinations are complicated by a lack of reported data, difficulty in calculating costs avoided, and failure to account for the cost of mandated benefits which would today be provided in the absence of a specific mandate.

While a comprehensive study of the cumulative cost of mandated health benefits in Florida has not been identified, several states have calculated these costs. A 1996 U.S. General Accounting Office report on claims costs in 6 states cited studies as far back as 1988, revealing claims costs ranging from 5.4 percent in Iowa to 22 percent in Maryland. Costs vary based on the number and type of mandated benefits.

In Virginia, a state with extensive cost reporting requirements for insurers and HMOs, the average claim cost per group certificate for the 1997 reporting period was $263, accounting for 16.62 percent of total claims costs. The premium impact on group certificates for family coverage was 29.17 percent of overall average premium on a full cost (as opposed to marginal cost) basis. Virginia had 33 mandated benefits according to the 1998 BlueCross BlueShield report.

[5]Note: The actual terms of the coverage may vary. House staff did not analyze the details of the specific coverages or compare deductibles or co-payments, or determine the extent to which the coverages meet the letter of the benefit mandated on insurers and HMOs operating in the private market place. This information should therefore be considered only as a starting point in any comparison of benefits among the different sources of coverage.

In Maryland, mandates were priced on a full cost and marginal cost basis. On a full cost basis, the estimated annual cost per policy for a group insurance policy was $604. The marginal cost came in at $148. This represents 15.4 percent and 3.8 percent of the average premium per policy. Maryland has 47 mandated benefits according to the 1998 BlueCross BlueShield report.

Maine calculates the cost impact of proposed mandated health benefits and also determines the cumulative costs of mandated benefits. As part of a December 22, 1999, report, the Maine Bureau of Insurance estimated the cumulative premium impact of 19 currently mandated benefits on group policies covering more than 20 employees to be 7.54 percent for fee-for-service plans, and 7.12 percent for managed care plans. For comparison purposes, the 1998 BlueCross BlueShield report showing Florida with 44 mandated benefits shows Maine with 31.

The Legislature has established requirements specific to consideration of legislation proposing mandated health benefits in Florida.[6] Proponents of a particular mandated health benefit must prepare a report assessing the social and financial impacts of the proposal and submit the report to the Agency for Health Care Administration and the relevant legislative committees. These include an assessment of the extent to which:

- The treatment or service is used by a significant portion of the population;
- The insurance coverage is generally available;
- Any general lack of availability of coverage causes persons to forego necessary treatment;
- Any general lack of availability of coverage results in unreasonable financial hardship;
- There is public demand for the treatment or service;
- The coverage is included in collective bargaining negotiations;
- Cost increase or decrease result from the treatment or service;
- Coverage will increase the appropriate uses of the treatment or service;
- The coverage will be a substitute for a more expensive treatment or service;
- The coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and,
- The coverage will impact the total cost of health care.

A survey conducted by staff of the House Committee on Insurance found 20 states have special statutory provisions for managing mandated benefits legislation and 28 do not.

The most common response of states has been to have an impact analysis conducted to assess the financial impact, social impact, and/or medical efficacy of the proposal. This is the case in 18 states. States typically require either a designated state agency or special review panel to conduct the review. In Maine, the review panel may contract with a private actuarial firm to complete the analysis. However, 7 states, including Florida, direct the proponents or sponsor of a mandates

[6]With other types of legislation, special constitutional or statutory requirements exist. These include legislation proposing changes in the state retirement system, creation of a public records exemption or specialty license plate, and approval of a local bill or local government mandate. The Legislature uses an estimating conference to consider fiscal impacts on the state employees group health plan. Both the Senate and the House of Representatives adopt rules, jointly and separately, defining the process for considering certain types of legislation--for example, legislation affecting appropriations--or conducting other legislative business. Special requirements can also be found in policy statements of several standing committees specific to legislative consideration of certain types of legislation.

proposal to complete the analysis. One state, Pennsylvania, permits both proponents and opponents to submit information. Two states, Louisiana and Tennessee, direct fiscal committee staff to conduct the review. For the most part, states call for a similar impact analysis. All include a financial component. Fourteen, including Florida, must include an analysis of the social impact of the proposal. Seven require the analysis to consider the medical efficacy of the mandate as well. Virtually all states include a laundry list of specific criteria to examine in conducting the analysis.

Time frames for submitting an impact analysis vary among states: at the time the proposal is filed (e.g., Oregon); within 30 days after analysis is requested (e.g., South Carolina); 90 days prior to session (e.g., Washington); timely manner (e.g., Maine); or before being heard or before final passage by committee (e.g., Kentucky).

Only 5 states directly attempt to limit the prerogative of the legislature to act on mandates legislation based on whether or not an impact analysis has been submitted. Maine is the most direct: "a proposed mandate may not be enacted into law unless [the] review and evaluation . . . has been completed."

Only 11 of the 48 states responding reported having either an ongoing permanent body or a state agency specifically charged with reviewing proposed mandated benefits.

Virginia and Maryland have standing commissions; Pennsylvania's Health Care Cost Containment Council must convene a Mandated Benefits Review Panel of 4 senior researchers to develop independently certified documentation for proposed mandates. The remaining states designate a state agency such as the Department of Insurance to review a proposed mandate if requested by either the appropriate legislative committee or, in some states, by the Governor's office. In Georgia, the Clerk of the House and the Secretary of the Senate must deliver any health insurance mandates bills to the Insurance Commissioner for a fiscal review within 5 days after first reading. Several state legislatures, Texas for one, have enacted legislation creating a temporary committee to study the costs and benefits of proposed mandated benefits. Missouri, likewise, approved legislation for a one-time study of mandated benefits.

Maryland and Oregon are 2 states with distinct limitations on legislative approval of mandated benefits legislation.

Maryland has attempted to limit the cumulative cost of all mandated benefits to a specific dollar amount. In Maryland, insurance carriers can only sell one insurance product to small employers--the product developed by the Health Care Access and Cost Commission (HCACC). In 1993, the Maryland General Assembly enacted an "affordability" cap on mandates costs for the small group plan. The cap is set at 12 percent of the average wage in the state. If the HCACC finds the cumulative cost of approved mandates exceeds this amount, the HCACC must adjust the level of benefits or cost sharing arrangements under the plan so the cap is not exceeded in the future.

In 1999, the Maryland General Assembly considered a similar approach for the large group market by requiring a comparison of mandates costs to the average annual wage in Maryland and to health insurance premiums. However, an actual cap was not imposed and benefits adjustments were not provided for. Instead, the calculations are used as the basis for triggering further review

by the HCACC. If the HCACC finds the full cost of mandated benefits exceeds 2.2 percent of the average wage in the state, then it must evaluate the social, medical, and financial impacts of each existing mandated benefit and report its findings to the General Assembly. The General Assembly can then use this information to decide whether or not to enact proposed mandates or repeal existing mandates.

The Oregon Legislature appears to be the only state which sunsets mandated benefits. Since 1985, Oregon law has provided for the automatic repeal of mandated benefits statutes 6 years from the effective date of the particular mandate. According to Oregon legislative staff, several mandates have expired under this law.

III. Effect of Proposed Changes:

The committee substitute provides for the Mandated Health Insurance Benefits and Providers Estimating Conference. The principals of the conference include:

- The Executive Office of the Governor
- The Insurance Commissioner
- The Director of the Division of Economic and Demographic Research of the Joint Legislative Management Committee and
- Professional staff of the Senate and the House of Representatives who have health insurance expertise.

The committee substitute permits designees to be appointed. The responsibility for presiding over sessions of the conference is to be rotated among the principals.

The conference is required to:

- Develop and maintain, with the Department of Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers, and other appropriate data.
- Prescribe the format, content, and timing of information that is to be submitted to the conference and used by the conference in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements are binding upon all parties submitting information for the conference to use in its assessment of proposed and existing mandated benefits and providers.
- Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the Legislature or the Governor.

When a legislative measure containing a mandated health insurance benefit or provider is proposed, the standing committee of the Legislature which has jurisdiction over the proposal must request that the conference prepare and forward to the Governor and the Legislature a study that provides, for each measure, a cost-benefit analysis that assesses the social and financial impact and the medical efficacy according to prevailing medical standards of the proposed mandate.

The conference has 12 months after the committee makes its request in which to complete and submit the conference's report.

The committee substitute prohibits the committee from considering a proposed legislative measure until 12 months after it has requested the conference's report on the measure.

The standing committees of the Legislature which have jurisdiction over health insurance matters must request that the conference assess the social and financial impact and medical efficacy of existing mandated benefits and providers. The committee must submit to the conference by January 1, 2001, a schedule of evaluations that sets forth the respective dates by which the conference must have completed its evaluations of particular existing mandates.

The committee substitute also amends s. 624.215, F.S. The committee substitute modifies a requirement that a report which assesses the social and financial impacts of proposed health insurance mandate be filed with the Agency for Health Care Administration and Legislative committees. Instead, these reports are to be filed with the Mandated Health Insurance Benefits and Providers Estimating Conference. These reports may be reviewed using a certified actuary.

The committee substitute requires the standing committee of the Legislature which has jurisdiction over the legislative proposal to request and receive a report from the Mandated Health Insurance Benefits and Providers Estimating Conference before the committee considers the proposal. The provides that the committee may not consider a legislative proposal that would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization until after the committee's request to the conference has been answered.

The committee substitute defines the term "health coverage mandate" to include mandating the use of a type of provider for purposes of s. 624.215, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Article III, s. 4 of the State Constitution, provides that each *house* shall determine its rules of procedure. Further, as the Florida Supreme Court has ruled in a series of cases, one of which

is *Neu v. Miami Herald Publishing Company,*[7] one legislative body cannot bind a future legislative body to an obligation. In *Neu*, which addressed the Public Meetings Law, the court stated " [a] legislature may not bind the hands of future legislatures by prohibiting amendments to statutory law."[8] Technically, the committee substitute does not prohibit amendment to statutory law, but prohibits the *consideration of* a mandated health benefit proposal by the standing *committee* that has jurisdiction over the proposal prior to receipt of a report on the mandated benefit from the Mandated Health Insurance Benefits and Providers Estimating Conference. However, in that the committee substitute attempts to limit the ability of future sessions of the Legislature to amend or create law related to mandated health insurance benefits prior to receiving the report, it would be ineffective. "The legislative power to deal with new situations as they arise cannot thus be limited, even though their action expressly or impliedly repeals former legislative acts."[9]

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

C. Government Sector Impact:

VI. Technical Deficiencies:

None.

VII. Related Issues:

There are a number of provisions in statute that require the Legislature to perform certain functions prior to adopting legislation. For example, s. 11.62, the Sunrise Act, provides that it is the intent of the Legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare. The section requires proponents of legislation that provides for regulation of a profession or occupation not already expressly subject to state regulation to provide, upon request, information to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees to which the legislation is referred. The agency is required to provide the Legislature with information concerning the effect of proposed legislation. The legislative committee, when making

[7]462 So.2d 821 (Fla. 1985).

[8]*Ibid* at 824.

[9]*Tamiami Trail Tours, Inc., et. al. v. Lee,* 194 So. 305 (Fla. 1940).

a recommendation concerning the proposed legislation, is required to consider whether the regulation is justified based on specific criteria, whether it is the least restrictive and most cost-effective regulatory scheme, and whether it is technically sufficient.

Another example of a statutorily-mandated legislative review process is contained in s. 119.15, F.S., the Open Government Sunset Review Act of 1995. The section requires all exemptions to public records or meeting requirements to expire in the 5th year after enactment. The provision states that it is the intent of the Legislature that exemption are created or maintained only if they meet certain requirements. Further, the section requires the Legislature to review exemptions and consider specific questions prior to reenactment of an exemption.

Neither of the processes outlined above, however, would actually restrict the Legislature from acting outside the processes contained in statute as one session of the Legislature cannot bind another. In other words, a future session of the Legislature could act outside of the established process contained in law, even without changing that statutory legislative process as the latest legislative action would take precedence over any previous law.

VIII. Amendments:

None.